**Deanship of Graduate Studies**

**AL-Quds University**


# Evaluation of Community Based Rehabilitation Programs in the North and Gaza Governorates

**Submitted by**

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# *Dedication*

***I dedicate this work to those whom I always love***

***My parents who pray for me and continuously encourage me***

***My sister Itidal for her patience***

***And***

***To my friends who supported me***

***Soad Jameel Radwan***

## Declaration

I certify that this thesis submitted for the degree of master is the result of my own work, and has not written to me in whole or in part by any other person(s), and that this thesis has not been submitted for a higher degree to any other university or institution.

Signed: Soad J. Radwan

Date: ----------

# Acknowledgment

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## *Abstract*

*Community Based Rehabilitation (CBR) is a specific and important strategy for people with disabilities. This study aims to evaluate the CBR programs in Gaza and North Gaza governorates inorder to provide information that could contribute to support the services delivery and enhance the effectiveness of the programs to disabled persons.*

*Evaluative techniques including triangulation methods combining both qualitative and quantitative techniques were conducted at the National Society for Rehabilitation and Palestinian Medical Relief Society. A sample of 300 beneficiaries have been chosen through a systematic random sample, and participated through a self-constructed interviewed- questionnaire with a response rate of 69.7%. Also, 10 key informants have been selected purposively for interview. In addition to that, 20 medical files were reviewed randomly.*

*The study results revealed the main causes of disability are acquired in 71.6% of cases with various types, mainly accidents that constituted (52.1%), followed by communicable diseases (16.7%), and wars (14.6%). Among disability types, physical disability is the commonest one that formed 76.1%. The prominent services were relief aids (42.8%), followed by assistive devices (28.6%) and physiotherapy (27.1%). There was lack in livelihood domain where vocational training forms only (0.5%), and lack of the income generation and disabled people employment, while the majority (80.6%) of disabled live under the poverty line.*

*The results indicated that 50.3% of visits are less than one visit monthly. Regarding the services provision, there is no difference between males and females. The researcher show that CBR programs are effective, this was elicited from response of the most of disabled's needs, and improvement in disabled physical health status (P value 0.001), and psychological state (P value 0.001). At the same time, positive proportional correlation was found between the provided services scores and improvement of quality of life domains that contained indicators like feeling security, satisfaction, change in physical and psychological health state and social participation of disabled people (Pearson correlation 0.376 - P value 0.001).*

*The study reflected good networking with different sectors, but governmental collaboration with CBR programs is still weak. On the other hand, communication and interaction of rehabilitation workers with disabled people was cooperative. The limited number of the rehabilitation workers and lack of volunteers increased the workload, and affect work's process and quality.*
*The study revealed shortage in the documentation and cases evaluation, poor public awareness about disability issues, and weak of the community ownership. Furthermore, application of the disability law number 4-1999 is inactive. This was indicated through the absence of disabled self- advocacy, and lack of the governmental role in maintaining disabled rights.*

*The study provided a set of recommendations that could strengthen the CBR programs including; establishment of a national strategy aiming to create public awareness about the disability issues, and formulating of a local committee for developing polices, empowering the disabled role in the community, enhancing the voluntary work, and developing of staff capacity.*

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## List of Abbreviations

| | |
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| **ADL** | Activities of Daily Living |
| **CBR** | Community Based Rehabilitation |
| **CBRPs** | Community Based Rehabilitation Programs |
| **CDC** | Center for Disease Control and Prevention |
| **CRWs** | Community Rehabilitation Workers |
| **CVA** | Cerebro Vascular Accident |
| **RWs** | Rehabilitation Workers |
| **DAR** | Disability and Rehabilitation |
| **DPOs** | Disabled People Organizations |
| **GG** | Gaza Governorate |
| **G S** | Gaza Strip |
| **ILO** | International Labour Organization |
| **KAP** | Knowledge, Attitude and Practice |
| **MDGs** | Millennium Development Goals |
| **MOH** | Ministry of Health |
| **NAD** | Norwegian Association of the Disabled |
| **NGO's** | Non Governmental Organizations |
| **NSR** | National Society for Rehabilitation |
| **PCBS** | Palestinian Central Bureau of Statistics |
| **PMRS** | Palestinian Medical Relief Society |
| **QOL** | Quality of Life |
| **SPSS** | Statistical Package for Social Sciences |
| **UN** | United Nations |
| **UNESCO** | United Nations Educational, Scientific and Cultural Organization |
| **UNRWA** | United Nations Relief and Works Agency for the Refugees of Palestine |
| **WB** | West Bank |
| **WHO** | World Health Organization |

# Chapter (1)

## 1.1 Introduction

Disability is a sensitive event that affects the human life. It has many types of pain including physical, emotional, psychological, social, and economical ones. An estimated 10% of the world's population, approximately 650 million people experience some form of disability or impairment and about 80% of people with disabilities live in developing countries (World Health Organization-WHO, 2006a).

There are different factors that can increase the number of disabled people such as population growth, ageing, and chronic conditions including diabetes, cardiovascular disease, and cancer. Crisis, injuries, birth defects, malnutrition, environmental degradation and other causes often related to poverty, all as well are contributing to cause the disability (WHO, 2006a).

Although disability is an umbrella term for impairments, activity limitations, and participation restrictions, 50% of disability is preventable and 20% of impairments are caused by malnutrition as iron, vitamin A, and iodine deficiency (Department for International Development-DFID, 2000).

According to the Palestinian Central Bureau of Statistics (PCBS, 2007), disability represents 2.7% in the Palestinian territories, 2.9% in the West Bank (WB) and 2.3% in Gaza Strip (GS), while the Palestinian Ministry of Health (MOH, 2010) reported that the disability in Gaze has increased to be around 5% after the Israeli war on Gaza on December 2008. This trend has created an overwhelming demand for health and rehabilitation services to the people with disabilities, their families, and the community.

The International Labour Organization (ILO et al., 2004) defined the Community Based Rehabilitation (CBR) as a strategy within general community development for rehabilitation, equalization of opportunities and social inclusion of all people with disabilities.

WHO has decided to include the CBR as a part of its goal "Health for all by the year 2000". Alma-Ata Declaration on Primary Health Care (PHC) has created a new vision for providing promotional, curative, preventive, and rehabilitative services for the main health problems in the community (WHO and United Nations International Children's Fund-UNICEF, 1978).

It also stated that people have the right and duty to participate individually and collectively in planning and implementation of their health care (WHO and United Nations International Children's Fund-UNICEF, 1978).

Recognizing that people with disabilities in developing countries have a large need for rehabilitation and have very limited access to rehabilitation facilities, WHO has developed a CBR programs which are designed to integrate with the programs for primary health care. Since then CBR usage as a tool for governmental and non-governmental interventions has been expanding very rapidly all over the world (WHO, 2009a).

WHO (2009a) emphasized on the goals of CBR which ensures the benefits of the convention on promotion and protection of the human rights of persons with disabilities by supporting them to maximize their physical, mental abilities, and also to maximize their access to regular services and opportunities, to achieve social justice and become active contributors inside the society.

In Palestine; CBR started with some pilot rehabilitation programs beginning in 1990. Gaza was the pioneer starting in 1990, followed by Jenin- in 1992 and the central region of the WB in 1993 (Eide, 2010). In Nablus and in the South Region, CBR Programs was recognized in 1995. The Regional Committees with Non Governmental Organization (NGOs) are partners in the development of the CBR, while technical and financial support to the CBR Programs are provided by the Norwegian Association of the Disabled (NAD/Diakonia) field office in Jerusalem (Eide, 2010).

The literature indicates that, the costs of managing disability are immense including direct and indirect costs, and those vary from country to another according to the country's gross national product, nature of the disability and how severe it is.

In the United Kingdom, the costs of disability estimated to average around 29 % of household income. The cost of disability is increasing according to the severity of restriction, such as costing vary from 40% and 49 % of income for those with severe restriction (Saunders, 2006).

The aim of this study is to evaluate the CBR programs to promote the implementation of CBR by the local societies providing CBR services in the Gaza and North governorates.

## 1.2 Research Problem

Politically, Gaza is a hot area. Its people live in emergency situation as they are exposed to sequences of troubles related to occupation. According to MOH (2010), disability has increased mainly after the war on Gaza in December 2008, and the estimation of injured cases was 5380 people, while the disabled people with different types of disability reach about 680 during the last war on Gaza that requires the more of rehabilitation services.

Disability often imposes considerable social, economical, and emotional costs on disabled people, their families, and their larger community. Thus it increases the burden on the Palestinian health care system as it requires special care, referral abroad and different kinds of rehabilitation devices that are expensive. MOH (2010) accounted the cost of expenditures for rehabilitation which purchased for disabled persons in the year (2009) in Gaza, as it was 9035 New Israeli Shakel (NIS) for each disabled.

Without effective rehabilitation programs, disabled people may have frequent complications, suffer dependency, being unhappy and becoming load to themselves, their families and to the society, taking into consideration the bad economic status, lack of resources and the stressful life of the Palestinian citizen.
Under these difficult situations the question will be whether the current CBR can face the needs of the disabled people, and run as a national model supported by several sectors.

## 1.3 Justification of the Study

It is strongly painful when the person loses any of his/her abilities, especially if those present and suddenly missed. Disability has adverse effects on disabled persons including the inability to carry out his/her normal Activities of Daily Living (ADL) compared to normal person in the same situation and age. To meet the needs of the disabled person as much as possible; it requires special and constant care and at the knowledge of the researcher institutions in this field of rehabilitation (CBR) are limited.

On the other hand, few evaluative studies about the CBR are available in Gaza governorates, besides that no one has the answer of the question "How far is the effectiveness of CBR?

Moreover, the Palestinian disabled persons deserve higher quality of care and a better life, so it is necessary to meet the disabled needs and integrate him/her into the all activities of the community. This study was conducted to evaluate CBR programs, which will lead to recommendations that may consolidate CBR programs in the North and Gaza governorate.

## 1.4 Aim of the Study

The overall aim of this study is to evaluate the CBR programs that provide services for people with disability in the North and Gaza governorates. This could help in developing the CBR services and add more benefits for people with disability.

## 1.5 Study Objectives

- To assess the services provided through the CBRPs for disabled people in Gaza and North Gaza governorates.
- To ascertain the effectiveness of the CBRPs in Gaza and North Gaza Governorates.
- To explore the strengths and weaknesses of the CBRPs in Gaza and North governorates.
- To set recommendations and suggestions that might promote the CBR services and enhance its benefits.

## 1.6 Research Questions

1. What are the CBR services provided to the disabled in Gaza and North Governorates?
2. To what extent the CBR services meet the needs of people with disabilities?
3. Are the CBR programs effective for disabled people in Gaza and North Governorate?
4. What are the indicators that constitute the effectiveness of the CBRPs?
5. What are the strong and weak points in the CBR programs?
6. Are there gaps in the CBRPs that need to be improved?
7. What are the recommendations that might help the decision makers for improving the CBR programs?

## 1.7 Context of the Study

The study was conducted in Gaza- Palestine. The researcher studied the demographic, socioeconomic, political and health context. In addition, she identified disability types and CBR activities. Furthermore, some information about the two societies that provides CBR services.

## 1.8 Demographic Context

Palestine constitutes the southwestern part of the geographical unity in the eastern part of the Arab world. It has an important strategic location as it is situated on the western edge of the Asia continent, and the eastern coastal area of the Mediterranean Sea (Palestinian Academic Society for the Study of International Affairs-PASSIA, 2009). Palestine is about 26,323 sq. Km. with 3,762,005 total populations in the WB and Gaza. Now, Palestinian Territory comprises two areas separated geographically, the WB and GS (PASSIA, 2009).

The GS is a narrow piece of land lying on the coast of the Mediterranean Sea. Its position on the crossroads from Africa to Asia made it a target for occupiers over the centuries. GS is very crowded place with an area of 365 sq. Km. The population density estimated was about 4,073 people per $KM^2$ (MOH, 2005). It is divided into five governorates: North, Gaza, Deir Al Balah, Khan-Yunis, and Rafah (MOH, 2005).

The total population of GS is 1,486,816 concentrated mainly in 7 towns, 10 small villages and 8 refugee camps (PCBS, 2010). The percentage of Gaza population from the Palestinian population living in the Occupied Palestinian Territory (OPT) composes 37.6%. The total number of Gaza's families is 219,220 families with average family size of 6.5 people (PCBS, 2010). There were 44.4 % of the populations in Gaza aged between 0 to 14 years, while 49% of the population in Gaza aged between 15-64 years (PCBS, 2010).

North Gaza governorate constitutes 17% of the total area of Gaza Strip and 1% of the total area of Palestinian territory with an area of 61 sq. Km (Annex 1). The total number of population living in North of Gaza is 270,246 with average size of household 6.7 individual (MOH, 2005). Gaza Governorate constitutes 20.3% of the total areas of GS and 1.2% of the total area of Palestinian territory with an area of 74 sq. Km, while the

total number of population living in Gaza Governorate is 496,411 with average size of household 6.5 individual (MOH, 2005).

## 1.9 Socioeconomic Context

Although the Israeli forces had left Gaza land, it still has the upper hand on borders and control travels in and out of Gaza and also has the power over entry of goods related to trade and commercial market (WHO, 2009b). The most significant socio-economic determinants in Gaza are the quality of food, lack of clean water and sanitation, the stress, the unemployment, poverty and social exclusion that clearly have an impact on people's health (WHO, 2009b).

In 2009, the unemployment rate increased from 23.5% in 2005 to 24.5% of the workforce, distributed 17.8% in the WB, and 38.6% in GS (PCBS, 2010). An estimation of the poverty by PCBS (2009) resulted that 21.9% of individuals in the Palestinian population suffered from poverty with 15.5% in the WB, and 33.2% in the GS, while 12.0% suffered from deep poverty 7.5% in the WB and 20.0% in the GS (PCBS, 2009).

It is important to notice that poor social circumstances associated with chronic malnutrition can affect the health of both adults and children negatively, the thing that can threaten people mainly the child’s survival as well as his/her physical and intellectual development causing some impairment or retardation.

The World Bank (2008) reported that poverty continues to increase in Gaza because of the crisis. At the same time, the Food and Agriculture Organization (FAO, 2008) indicated that, the proportion of food insecure households in Gaza was 56% before the crisis and this is considered a high percentage especially within the difficult situations and lack of resources.

## 1.10 Political Context

Palestinian people live in an unstable situation because of the current Israeli occupation, while the Israeli army conducts different kinds of violations and military invasions with human rights abuses. According to the WHO (2009b), the war on Gaza between 27 December 2008 and 18 January 2009 resulted about 1380 Palestinians were killed of whom 431 were children and 112 women (WHO, 2009b), and the others from men, elders and health staff. In addition, there are 5380 injured people who are need treatment

or urgent surgery, rehabilitation services and follow up. This is not all; again Gaza's people are exposed to other violations types like destruction of the Palestinian houses which lead them to displace their residence searching for shelters. Furthermore, destruction in the health facilities infrastructure and damage of farming land that ended the Palestinian people with on-going insecurity.

The United Nations- UN (2009) reported that the blockade of the Gaza Strip continues to affect the entry of major essential supplies such as Medical supplies, Materials needed for rehabilitation**,** construction equipment, lack of spare parts for water and wastewater infrastructures to Gaza and intermittent shortages of fuel, and electricity (UN, 2009).

Heath is not the only sector that has been influenced with political situation in Gaza governorates. Many sectors also are affected like agriculture, livelihood**s,** and industry**.** In relation to disability; siege and closure in several times prevented or delayed the arrival of necessary human aids and assistive devices like crutches, wheelchairs, cane and others. There has been obvious increase access to International Non-Governmental Organizations (INGOs) staff to Gaza through Erez Crossing, particularly after the last war on Gaza on 27/December 2008 (UN, 2009). So INGOs can help through provide and facilitate the arrival of essential materials like prosthesis, and technical aids providing to victims with amputation, and supply injured people with different equipment.

## 1.11 Health Care Context

The provision of health services in the Palestinian national authority (WB and GS) is shared by the four major providers, (MOH), United Nation Relief and Works Agency for the refugees in Palestine (UNRWA), (NGOs), and the private sector. MOH plays the main role in providing health care services to Palestinian people. It provides physical therapy in some hospitals, and primary health care centers but, in many times it purchases the rehabilitation services through contracts from other nongovernmental health facilities such as Al Waffa hospital.

UNRWA provides physical rehabilitation services for the refugees through their primary health care centers.

NGOs also provide rehabilitation services extensively for women, men and children. In Gaza, there are 71 rehabilitation centers or societies offer rehabilitation services operated by NGOs (Sagalla, 2011). The most part focusing on one or a limited number of

disabilities such as hearing and speech impairment, visual impairment, physical disability like spinal cord injuries, and cerebral palsy. The war on Gaza created an obvious active role of some national and international NGOs that concern with physical disability associated with amputations as EL-Waffa Hospital, El-Salama society, the Palestinian Red Crescent society, Medecins Sans Frontieres (MSF) and Palestinian Medical Relief Society (PMRS).

For mental health services, facilities for inpatient or outpatient in the MOH are limited, but in this type of disability the NGOs contribute more than other sectors in mental health rehabilitation programs. The Gaza Community Mental Health Program which is the largest of these has a network of prevention, detection and screening, while treatment services including four centers specifically targeting women (WHO, 2006b).

Related to database system for estimation of disability in Gaza, Abed (2007) reported that there is no available database system at the national level, and the health sector lack a systematic way for collection of data or information on disability resulting from all causes like road traffic accidents, congenital anomalies and others.
In Gaza, there are two main institutions for CBRPs. Those are: The National Society for Rehabilitation (NSR) and Palestinian Medical Relief Society (PMRS) and about them extra details will be coming later.

### 1.11.1 Disability in Palestine:

According to the (PCBS, 2007) the percentage of disability in the Palestinian territory was 2.7%, distributed in WB and Gaza. In the WB the percentage of disability was 2.9%, while in Gaza it was 2.3%.

Disability is higher in camps and lowers in urban areas, perhaps this is related to political instability in camps and rural areas and to Israeli invasions more than urban areas. PCBS (2007) reported that males have higher rate 3% of special needs compared to females with 2.3% and this is attributed to more exposure of male to violent events through their involvement in labor force or political activities.

The most common type of disability in the Palestinian territory is physical disability at 1.29%. 1.36% in the WB and 1.18% in Gaza followed by visual impairment which forms 0.76% in Palestine; extend 0.95% in West Bank and 0.48% in Gaza Strip (Annex 2).

WHO (2009b), reported that during the last Israeli military strike, at least 5,380 people were injured. Among the reported injures 33% were inflicted in Northern GS and 38% in Gaza City, and from those 1,872 are children and 800 are women, mostly with multiple traumas of head, thorax and abdominal wounds resulted permanent disabilities such as amputation and disfigurement (WHO, 2009b).

A preliminary estimation on the basis of the type and the severity of injury indicated that about 30% of injured people due to the last war on Gaza between 27 December 2008 and 18 January 2009 will have long-term of disabilities, so for those, more rehabilitation services was required (WHO, 2009b).

### 1.11.2 History of CBR in Palestine:

In Palestine the CBR started with various pilot rehabilitation programs beginning in 1990. Gaza is considered the pioneer starting in 1990, followed by south of WB – Jenin in 1992, and the central region of WB in 1993 (Eide, 2010).

Establishment of CBR Programs in the South region and in Nablus was in 1995. The regional committees with NGOs are in charge of CBR development in the respective regions, while Norwegian Association of the Disabled NAD/Diakonia was responsible for the technical and financial support to the CBR Program.

The Foundation for Scientific and Industrial Research at the Norwegian Institute of Technology (SINTEF) Health Research visited Palestine in 2000 for the decision on the viability of conducting an impact assessment of the CBR Programs in Palestine. Especially judgment on methodological issues and problems related to conducting such a study in a conflict area. Subsequent to that visit; an agreement between NAD and SINTEF in January 2001 was made in order to plan for the study, data collections, analyses and report writing which have been carried out until June 2001 (Eide, 2010).

### 1.11.3 The National Society for Rehabilitation (NSR):

The National Society for Rehabilitation (NSR) in GS was established in 1990, as a base for the National Committee for Rehabilitation and it was registered in the Ministry of Interior in 1993. NSR was initially composed of the following members:

Red Crescent Society, Arab Women Union, Central Blood Bank Society, Ahli-Arab Hospital, Near East Council of Churches (NECC), Arab-Medical Association and UNRWA.

The NSR has started its activities in Beach Refugee and Bureij Refugee Camps through building the first model of Community-Based Rehabilitation (CBR). Thus, as a result of its achievements, it has generalized the concept of CBR and administered it over 13 geographical localities in the Gaza strip, which includes four governorates; Rafah, Khan Younis, Middle Zone, and Gaza (NSR, 2009).

The NSR covers about 75 percent of the total area of GS (NSR, 2009). It aims to assisting physical or psychological disabled persons and improving their integration into the community. The society is trying to enhance channels of communication and coordination among related bodies, facilitate the training of local human resources, implement rehabilitation projects at the community level, encourage activities aiming at the prevention of disabilities, and promote public awareness towards the disability (NSR, 2009).

### 1.11.4 Palestinian Medical Relief Society (PMRS):

The Palestinian Medical Relief Society (PMRS) is a community- based Palestinian health organization. PMRS was founded in 1979 by a group of Palestinian doctors and health professionals seeking to supplement the decayed and inadequate health infrastructure caused by years of Israeli military occupation. It is non-profit, voluntary, and one of the largest health NGOs in Palestine.

The core principle of PMRS' work is the participation and involvement of local communities; it involves itself in all aspects of community development, especially by working with young people, and by supporting community institutions. It adopts the national health programs that emphasize prevention, education, community participation, and the empowerment of people (PMRS, 2011).

The PMRS operates 25 community health centers in towns and villages throughout the West Bank and Gaza Strip, and 15 specialized centers including physiotherapy centers, youth, and community centers and medical equipment loan centers (PMRS, 2011). Through these permanent facilities and through its mobile clinics, the PMRS conducts comprehensive Primary Health Care programs including women's health, child health, community-based rehabilitation, school health, and specialty services.

The Palestinian Medical Relief Society established CBR programs in many areas as Ramalla, and Jenin in WB. In addition, establish its work in Khan Younis and in Jabalia in the North governorate (PMRS, 2011).

## 1.12 Definitions of terms

**Evaluation**: is the systematic examination and assessment of the features of an initiative and of its effects, in order to produce information that can be used by those who have an interest in its improvement or effectiveness (WHO, 1998).

**Community**: is defined as a group of individuals living together, with similar interests and having the same ideological, religious, cultural and economic aims (Mpagi, 2002).

**Rehabilitation**: is the combined and coordinated use of medical, social, educational and vocational measures for training or retraining patients with disabilities to the highest possible level of functional abilities (Helander, 1999).

**The Community-Based Rehabilitation** is a strategy with in the community development for the rehabilitation, equalization of opportunities and social integration of all people with disabilities. CBR is implemented through the combined efforts of disabled people themselves, their families, and communities, and the appropriate health education, vocational and social services (ILO/UNESCO/WHO, 1994).

**The Community Based Rehabilitation**: It is a strategy within general community development for rehabilitation, equalization of opportunities and social inclusion of all people with disabilities (ILO et al., 2004).

**Disability**: Any restriction or lack resulting from an impairment of the ability to perform an activity in the manner within the range considered normal for a human being (WHO, 1980).

**Disability:** means impairment, activity limitation and participation restriction in social activities (ICDF, 1990).

**Impairment**: Any loss or abnormality of body structure or of a physiological or psychological function (WHO, 1997a).

**Handicap:** is defined as a disadvantage for a given individual, resulting from an impairment or disability that limits or prevents the fulfillment of a role that is normal depending on age, sex, social and cultural factors for that individual (WHO, 1980).

**Disabled person**: An individual whose prospects of securing, returning to, retaining and advancing in suitable employment are substantially reduced as a result of a duly recognized physical, sensory, intellectual or mental impairment (Perry, 2003).

**Participation**: The nature and extent of a person's involvement in life situations in relationship to impairments, activities, health conditions and contextual factors (WHO, 1997a).

**Effectiveness**: does the CBR produce intended results (WHO, 2003).

**Organizations of persons with disabilities**: Organizations that represent persons with disabilities and advocate for their rights (Perry, 2003).

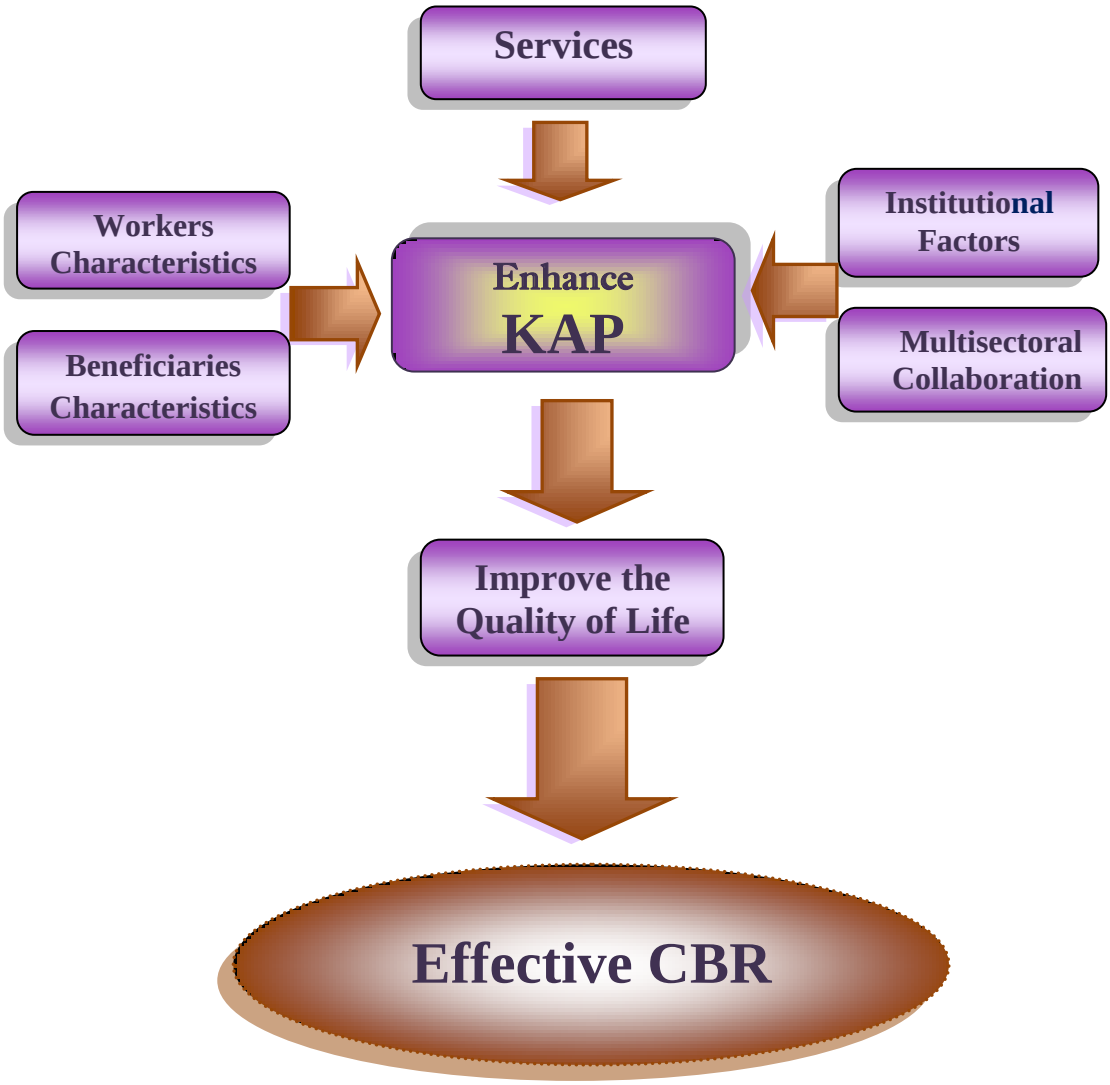
# Chapter (2)

# Literature Review

## 2.1 Conceptual Framework

The conceptual framework is the conceptual map that guides for the implementation of the study, and it is an efficient method for demonstrating and summarizing variables of the study in a figure. The researcher builds up the conceptual framework that addresses the primary aspects of this study after reviewing the available literatures about the evaluation of CBR programs through identifying categories that affect and affected by CBR programs.

**Conceptual Framework**



### 2.1.1 Beneficiaries Characteristics:

Beneficiarie's characteristics contain the demographic characteristics, socioeconomic status which may contribute in the increasing of the disability. Also it includes the monthly family income, the level of education of the disabled person that reflects the recognition of disability and the cooperation with community rehabilitation workers.

### 2.1.2 Workers Characteristics:

Workers Characteristics is very important for good implementation and effective results. This includes the profession of rehabilitation workers, their experience, and the training courses which they had for providing qualified services to disabled people.

### 2.1.3 Services:

Services is important to reduce the impact of impairments, assist disabled people to increase their level of independency in their daily living and enable them to meet their needs and access their rights. Services are varying according to the type of disability; it includes physiotherapy, occupational therapy, speech therapy, assistive devices, environmental adaptation, social inclusion, employment, vocational training and others.

In this study the researcher assessed the type of services, and the process of its provision which reflects how it organized, delivered, and used, its accessibility and difficulties. In addition, assess the interaction between the rehabilitation staff and clients.

### 2.1.4 Multisectoral Collaboration:

Multisectoral collaboration considers an essential part in the success of CBR programs. Such these are: UN Global Programs on disability which focuses on norms and standards rather than field operations, while participation, equal rights and accessibility are the key themes of it.

In addition, NGOs, stakeholders, government represented by different ministries such as; MOH, Education, Finance, Ministry of Labour, Social Affairs and others that support disabled people and assess in developing the CBR programs.

### 2.1.5 Institutional Factors:

This includes leadership, volunteers, and Facility characteristics; leadership in a community based organization is the most important ingredient for survival. Without it, the organization and their programs may flounder and possibly fail. Wiens, (2006) talked about the role leadership of community organization; he said that, leadership skills and organizational competencies in a community organization mirror business principles that place value on integrity, commitment, and competence. Facilitating organizations can care for the development of these principles through long term relationships that encourage mutual learning and trust (Wiens, 2006).

In addition, it contains characteristics of the facility that provides services for disabled people, the presence, or absence of things which facilitate accessibility to it.

Another factor is the number present of the volunteers in the organization; recruitment and training of volunteers who are responsible for transfer of knowledge and skills to disabled persons, their families, and community members. Volunteer's active role will help in mobilizing the community and sharing in the success of CBRPs.

The previous factors will affect in the achieving of the outcome of the programs which include enhance the Knowledge, Attitude, and Practice (KAP) of the disableds, the family and the community through increase information, added facts toward disability, its causes and prevention. Also the programs act to change toward the positive attitude, and improve practice about how to deal with disability, and how to utilize available resources in the community to rehabilitate disabled persons, assist their family, and the community in order to improve the quality of life for them.

## 2.2 What is Program Evaluation?

CBR programs contribute to improving the quality of life for disabled people. The provision of systematic services is often delivered through structured programs. A program is any group of related, complementary activities intended to achieve specific outcomes or results.

It is necessary to identify the extent of a program goals achievement, determine if a program meets the needs of participants, methods to improve program and determine the effectiveness of a program to stakeholders and sponsors. Evaluation is the systematic

examination and assessment of the features of an initiative and of its effects, in order to produce information that can be used by those who have an interest in its improvement or effectiveness (WHO 1998).

The main focus of the program evaluation is to measure the effectiveness of the program in the light of the attainment of its goals. Grinnel and Unrau (2008) defined Program evaluation as a form of appraisal using valid and reliable research methods, that examines the process or outcomes of an organization with the reason of exists to fulfill some social need. There are many different types of evaluations depending on the object being evaluated and the purpose of the evaluation.

Indicators are one of the evidence aspects of program evaluation those typically affect perceptions of credibility. It translates general concepts regarding the program and reflects many aspects that are meaningful for monitoring. Indicators that be tracked are various, some includes measures of program activities as the program's capacity to deliver services; the participation rate; levels of client satisfaction; the efficiency of resource use; and the amount of intervention exposure. Others measure the programs effectiveness as changes health status, quality of life, participation, policies or practices (Center for Disease Control and Prevention - CDC, 1999).

The most important basic distinction in evaluation types is that between formative and summative evaluation. Formative evaluation is carried out at the same time as the program is being developed and implemented. It is frequently concerned with the process and provides essential information and feedback to guide program development. Also it leads to decisions regarding what needs to concerned, what things to be added and what things to be excluded (Green and South, 2006).

Summative evaluation is carried out toward the end of an intervention to assess achievement, while the emphasis tends to be on outcome. Summative evaluation indicates a retrospective analysis and includes change in attitude, knowledge and practice (Green and South, 2006).

## 2.3 Methods to Collect Information for Evaluation

There are many different methods for gathering data. The evaluator should select the method that best suits his /her needs. Marynowski, et al., (2006) mention evaluation forms of data that could be collected. They are quantitative and qualitative approaches. Quantitative and/or qualitative evaluation approaches depend on evaluation purpose,

program needs, and evaluation questions to be answered. To get more comprehensive answers, it is best to gather both kinds of data (Marynowski et al., 2006).

Quantitative data uses numbers or rankings to identify or to measure program components, also it used for comparing, categorizing, and evaluating the effects of the program. Quantitative data are most suitable to evaluate large-scale programs, generalize results to large population, measure levels of knowledge and attitudes, determine if changes are statistically significant, and rank features of different groups. It consider easy to analyze than the other approach (Marynowski et al., 2006).

Thus qualitative data collection methods include: in-depth structured or unstructured interviews to deg deeper including oral and life histories; group discussions and interviews; observational studies, and analysis of textual and narrative sources such as reports and letters. Qualitative methods are appropriate to understand attitudes, measure and understand behavioral change, recognize outcomes or impact of services (Carter and Henderson, 2005).

## 2.4 Benefits of Evaluation

Traditionally, evaluation aims to describe the context of the program; input, process, and output, and to make judgment about the program's value, then to set suggestions and recommendations for change.

WHO, (2010) talked about the benefits of evaluation; as it helps to determine whether the outcomes outlined in the program plan have been met or not, and how the situation on which they were based has changed. It can lead to a decision to continue, change or stop a program, and can also provide important evidence related to CBR strategy (WHO, 2010).

Marynowski et al., (2006) illustrated that, evaluation can assist in determine how well a program is running. It measures and explains program performance, outcomes, and impacts. Also, evaluation determine strengths and weaknesses of a program as it shows if the objectives are met or not so, you can defined areas that need improvement and make the suitable modifications.

Furthermore, evaluation generates the evidence to gain more support since it provide useful feedback related to a program to others including; organizational administrators,

program staff members, program participants, sponsors, and other stakeholders (Marynowski et al., 2006).

## 2.5 Major Strategies for Rehabilitation

WHO, (1994) mentioned the main types of rehabilitation services provided for persons with disability. Those are: institution-based rehabilitation, outreach rehabilitation, and community- based rehabilitation.

### 2.5.1 Institution – Based Rehabilitation Services:

This type of rehabilitation offered in a hospital or in a clinic where disabled people received special treatment or short – term therapy. It focuses on the person's disability and gives little attention to the person's family and community. It is characterized with high cost and its location usually in urban centres, making it difficult to get to those living in remote areas.

In addition, specialized institutions often lack qualified personnel, in the time that competent institution – based care is an important part of the rehabilitation referral system for the provision of surgical interventions, special assessments and equipment, and other skilled treatment (WHO, 1994).

### 2.5.2 Outreach Rehabilitation Services:

In general, outreach rehabilitation provided by health care personnel based in institutions to the homes of people with disabilities. The focus is on the disabled person, and perhaps the person's family. Usually, in this type of rehabilitation vocational training and education are not included and community involvement in these services is limited with little social change and high cost per person for treatment (WHO, 1994).

### 2.5.3 Community Based Rehabilitation (CBR):

CBR is characterized by the dynamic role of people with disabilities, their families, and the community in the rehabilitation process. In this kind of rehabilitation, knowledge and skills for the basic training of disabled people are transferred to disabled adults themselves, to their families, and to community members. In addition, a community committee promotes the removal of barriers such as physical and attitudinal one and

ensures opportunities for people with disabilities to participate in school and community activities.

CBR concerned with attend the disabled children to local school, provide local job training for disabled adults, support community resources by referral services within the health, education, labour, and social service systems, train and support community workers, and provide skilled intervention (WHO,1994).

## 2.6 Concept of the CBR Programs

The concept of the CBR came after the Alma-Ata Declaration (1978). The WHO Expert Committee on disability prevention and rehabilitation proposed CBR as an alternative approach to the usual institution-based system which deal with the needs of people with disabilities in low-income countries.

The International Labour Organization (ILO et al., 2004) defines the CBR as a strategy within general community development for rehabilitation, equalization of opportunities and social inclusion of all people with disabilities.

The fundamental objectives of CBR are to ensure that disabled people are able to access services and opportunities, maximize their abilities, to develop into contributors in the society and to protect and promote human rights (ILO et al., 2004).

WHO, (2010) confirmed the mission of national CBR program that is to empower people with disabilities, their families and communities regardless of color, creed, religion, gender, age, type and cause of disability through raising awareness, promoting, inclusion, reducing poverty, eliminating stigma, meeting basic needs and facilitating access to health, education and livelihood opportunities.

WHO, (2010) also illustrated that CBR programs are decentralized to the community level with most activities as; raining awareness of family and community members, providing financial assistance for living, education and home modifications, referring people with disabilities to special services, and others (WHO, 2010).

Concerning the CBR strategy, Cornielje et al., (2008) described the CBR as a model of providing support in the community and it has several contexts as, social, historical, cultural, economical, & political one. The empowering approach of CBR based on essential principles of human rights such as the same chance for disabled people and full participation in the community without discriminations (cornielje et al., 2008).

At the same time, Kamaruddin (2007) stated that CBR is considered a cost effective model, and an effective alternative to institutional rehabilitation of people with disabilities.

The implementation of CBR programs requires partnership and combined efforts from various aspects such as national and international organizations, people with disabilities, their families, and communities. Evolution of CBR concept has happened without changing the above objectives. The evolution emphasis was on human rights and action to deal with inequalities, expanding role of Disabled People Organizations (DPOs) and alleviation of poverty.

WHO(2009a) reported that CBR focus is on enhancing the quality of life for people with disabilities and their families, meeting basic needs beside ensuring inclusion and participation in the community life. Also, it described CBR as a multisectoral approach that has five major components; health, education, livelihood, social and empowerment.

## 2.7 Essential Elements of CBR

For CBR successes, it is not enough to require only community and disabled people organizations to do the work because they cannot work alone to ensure equal opportunities for people with disability. Thus national polices, NGOs and other stakeholders or multisectoral collaboration were needed (ILO et al., 2004). Other elements that contribute to the sustainability of CBRP include support of national level through co-ordination and resource allocation, volunteerism, recognition of the needs of CBRPs, willingness of the community to respond to the needs of disabled, and the last is the presence of motivated community workers.

## 2.8 Evolution of Community Based Rehabilitation

Over the decades, development of CBR has been influenced by concerns that have contributed importantly to the evolution of the CBR concept and resulted in increased recognition of discrimination and exclusion, and the need to address social and political aspects of disability.

The first introduction of CBR was in the early eighties, and there were several positive changes that have taken place since that time. Many factors have the influence of

producing the change through different national/international declarations such as ILO and the UNESCO which advocates for inclusion of disabled in education.
Also, the UN Standard Rules confirmed on the equalization of opportunities for People with disabilities that influence the conceptualization of CBR to be more effective as a development strategy (WHO, 2003). In addition, concerns of disabled people themselves at the community level and by disabled people's organizations.

There are many views of CBR evolution such expanded the CBR from medical rehabilitation where the idea that CBR is merely a form of therapy in the community towards more comprehensive approaches such as promotion of equal opportunities and protection of rights by access to total health care, education, vocational training, employment and income generation programs (WHO et al., 2007).

Another form of the evolution of the CBR was the shift from service delivery to management issues that influence the effectiveness and the quality of services and realize the human (WHO, 2003). The major change is the transfer from restoration from functional ability in an individual, to community attitude and contextual factors; that means social integration and change the attitude toward disability in the context of disabled own community (WHO et al., 2007).

Recently, CBR is considered as an essential part of community development and empowerment programs and there is greater emphasis on information sharing and networking sometimes facilitated by donor agencies.

## 2.9 Community Based Rehabilitation Stakeholders

Stakeholders are the individuals, groups or organizations that might benefit from, contribute to, or influence a CBR program. Finkenflügel (2006) talked about CBR stakeholders, he said that the most prominent stakeholders in the community are the person with a disability, the family, trainer; specialists including highly qualified professional rehabilitation workers. In addition, the medical doctors in training institutes and treatment centers at the national level and the local supervisor. Finkenflügel (2006) illustrated that; levels of knowledge and experience about disability and rehabilitation are demanded for CBR implementation.

## 2.10 Disability and Poverty

Disability and poverty have a strong correlation; a forceful cycle links the disability and poverty. While poverty leads to increase the disability, it in turn leads to increase the poverty. People with disabilities often become poorer for meeting their healthcare expenses, and consequently poverty has a negative impact on health because poor health and disability can cause or increase poverty by growing isolation and economic strain, not just for the individual but often for the affected family too.

Approximately 80% of disabled live in low income countries, where they are living in poverty and have limited or no access to basic services, including medical and rehabilitation facilities (WHO, 2006a). According to Elwan (1999), disabled people have been estimated to make up about 20 % of the poor in developing countries.

In fact, disabled persons exposed to aspects of exclusion and marginalization that reduce their opportunity to contribute productively to their household and the community, and this added increases the risk of poverty (WHO et al., 2007).

The Millennium declaration set Millennium Development Goals (MDGs) that are relevant to disability. The three goals that concern the disabled people and their families are: eradicate severe poverty and hunger, achieve universal primary education and promote gender equality and empower as disabled women and girls face a complex experience of discrimination (United Nation- UN, 2000).
For that, countries are invited to develop strategies to address the MDGs and begin poverty alleviation measures to ensure the participation of disabled. WHO (2003) insisted through a review of CBR held in Helsinki (2003) on the poverty as the most important issue affecting the lives of disabled people and recommended the focus of CBR programs on the reduction of it.

## 2.11 Human Rights and Disability

People with disability suffer from various forms of discrimination such as exclusion from mainstream society, distinction, and denial of opportunities. The United Nations (UN) played a key role in securing the rights of disabled people. The UN general assembly develop various conventions as the international year of the disabled in (1981), standard

rules on the equalization of opportunities for persons with disabilities (1994) that contributed to increase awareness and advocate to disabled people rights. Again in 2006 the UN general assembly reaffirmed the rights of persons with disability which depend on fundamental principles as respect for dignity, respect children's right, men and women equality, accessibility, non-discrimination and ensured the full and equal enjoyment of human rights as involvement in education, social, cultural, religious, economic, and political activities (UN, 2006).

The CBR promotes the rights of people with disability to live with equal opportunities within the community. Office of high commissioner for human rights (2010) reported that, several conventions concerned with the protection and promotion of the rights of disabled have been shifted towards disability "right based approach" focusing on the human being, which means viewing disabled as a subject of law rather than charity-based or object of treatment and assistance.

According to the Palestinian legislative council (1999), the Palestinian disabled has the right to live as any normal citizen, and the disability should not restrict him to access the rights. The Palestinian legislative council confirms on the law of disability- number 4 that approved in 1999, and verifies the responsibility of government to keep those rights, and facilitate the availability and accessibility of services to disabled people. Such these rights are: the right in health services with free insurance including diagnostic, curative, preventative, early detection of the disability and provision of assistive devices related to the nature of the disability.

In addition, provision of social assistance includes all type of disability, environmental adaptation that’s guarantee the movement of the disabled people mainly in general situations, and the right in education through schools and universities attendance. Again, rehabilitation and vocational training with organize a suitable cadre for this duty, and offer opportunities for at least 5% of disabled people for employment (Palestinian legislative council, 1999).

## 2.12 Disabled People Organizations (DPOs)

Today, DPOs have a critical role in representing disabled people as raising awareness of disability issues, advocating and lobbying for the rights of disabled people and holding the state and specialist disability service providers to account (Thomas, 2005).

ILO et al., (2004) mentioned that, DPOs take meaningful roles in the initiation, implementation and evaluation of CBR programs. At the same time, they known as a resource to strengthen CBR since DPOs representing people with disabilities and struggle to make their needs known and to promote appropriate measures to address those needs and reach them to be more active in the society.

Two major types of DPOs have become active participants in CBR programs: cross-disability organizations representing people with disabilities without regard to the type of impairment; and single-disability organizations representing only those individuals who have a disability related to a specific impairment, such as seeing or hearing. The cross-disability organizations have an essential role to play from national to community level and in influencing leaders and policy makers about rights including equal access, but single-disability organizations creates an important contribution at all levels by advising on the needs of people with specific types of impairments (ILO et al., 2004).

Although CBR programs support the communities, DPOs, and local government through developing a range of leisure and recreational activities that are effective for children and adults with disabilities, there are some challenges that face DPOs and consider barriers to their development and participation. These difficulties as lack of transportation, lack of accessible information and communication difficulties in the moment that some people with disabilities require special services such as sign language interpretation, Braille equipment, guides or transport (WHO et al., 2007).

## 2.13 Community Rehabilitation Workers (CRWs)

WHO, (2010) considered the CRWs are the key in the implementation of CBR. Their responsibilities include achievement of home-based rehabilitation, identifying people with disabilities, carrying out basic assessments of their function and providing of therapeutic interventions. Also, they educating and training family members to support and help people with disabilities, providing information about services available within

the community, and linking disabled persons and their families with these services via referral and follow up.

On the other hand, CRWs assisting people with disabilities to form disabled people's organizations, advocating for improved accessibility and inclusion of people with disabilities by making contact with health centers, schools and workplaces, raising awareness in the community about disability to encourage the inclusion of disabled people in family and community life (WHO, 2010).

Training and guiding of the RWs is essential for supporting and sustaining the CBR programs and this is established by expertise including physicians, physiotherapist, psychiatrist and others. It is important to know that, the primarily role of RWs is a trainer, facilitator, and consultant not health provider, because they help disables people in several things as training, and facilitates the development of a plan of rehabilitation (Judd, 2009).

## 2.14 Volunteers in CBR

Community volunteers are one of the important issues in CBR. Their role is perceived as vital of the major subjects for CBR projects in different parts of the world, particularly in the light of current emphasis on community participation (WHO et al., 2007).

The intent of recruitment and training of volunteers is to maintain a cadre of capable and committed volunteers who selected locally by the community and should have the confidence of people and thorough knowledge of their local culture and language and better access to community members. They are catalysts for ongoing and sustainable program through community's participation and ownership (Deepak and Sharma, 2001).

In CBR programs, recruitment of volunteers considered particularly where resources are limited. Volunteers are not paid for their job; instead, they usually receive incentives and resources to help them do their jobs. In reality, recruiting volunteers has both advantage and disadvantage items. For example, while volunteers are cost- effective and usually have good local knowledge; they can work well but, they often have limited time so, turnover in volunteer is high since they are actually hoping for a paid employment in the future, unless they see their voluntary work as exploitation ( WHO, 2010 ; Deepak and Sharma, 2001).

In regard to the vital role of volunteers in CBR, Reimer and Lenavenec (2005) in their study titled rehabilitation outcome evaluation after very sever brain injury, confirmed the

feasibility and the effectiveness of CBR programs delivered by volunteers. They verified that much success of CBR programs has been based on the recruitment and training of volunteers, while most of them provides three hours or more a week of one-on-one therapy of particular clients in their community. Each one has individualized program established and monitored by the therapy team (Reimer and Lenavenec, 2005).

## 2.15 CBR Enhance Knowledge, Attitude and Practice (KAP)

People with disability required experience about their conditions; know how to deal with it, how to adopt it, and how to overcome the challenges which face them. At the same time, they undergo shifts in their attitudes including alter in belief, feeling and behavior resulting from the sense of social discrimination or vulnerability.

Develop a good attitude is an essential component of CBR programs. This was recognized via social interventions interested in the process that leads people to change their attitudes in a positive direction.

Dalal (2006) examined the possibilities of changing attitudes towards persons with disability in rural communities in India using some indicators as increased visibility and participation of people with disabilities in community activities in various areas like health centers, community meetings, schools, and social celebrations. He found that many of disables indicate changing of public attitude by stepped out of their houses and participation in public life, attending the meetings called by the CBR Committee and respondent to immunization more than in the past (Dalal, 2006).

## 2.16 CBR Improve the Quality of Life for Disabled People

According to WHO (1997b), Quality Of Life (QOL) is an individual's perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns. WHO (1997b) reveals the quality of life as a broad ranging concept affected in a complex way by the person's states. Fayers and Machin, (2007), demonstrates the quality of life as multidimensional construct as it related to several concepts such as physical, emotional, and social aspects that interplay between domains and contribute to quality of life.

CBR was designed to enhance the quality of life for people with disabilities through community initiatives which have a serious impact on them. This was achieved by

delivery of services and development of issues that includes environmental protection, as well as health, education, sanitation, safe drinking water, housing and transportation (WHO et al., 2007).

Schalock (2004) mentioned eight domains of quality of life, those are: physical and emotional wellbeing, social inclusion, interpersonal relations, personal development, self-determination, material well-being, and rights.

Measuring quality of life is established by setting of indicators which connected with the previous domains. The indicators are different such as self care skills, satisfaction, community integration and participation, social contacts, education, respect and others (Schalock, 2004).

## 2.17 Sustainability of the CBR

In reality, benefits of the programme must be lasting, and the program is not sustainable if it needs continued external support to remain viable (WHO et al., 2007).

The CBR activity must be sustainable beyond the immediate life of the programme itself, able to continue beyond the initial intervention and thrive independently of the initiating agency (WHO et al., 2007). There are several elements that contribute to the sustainability of CBR programs include support of national level through co-ordination and resource allocation, volunteerism, recognition of the needs of CBRPs, readiness of the community to respond to the needs of disabled, and the last is the presence of motivated community workers (ILO et al., 2004).

At the same time, Lightfoot (2006) stated that it is essential to keep the community workers have an incentive to continue participating in the program and thus the sustainability of it.

## 2.18 CBR Guidelines

Collaborative efforts by the WHO, ILO and UNESCO were made to develop a guideline to make CBR an effective, multisectoral strategy and support intersectoral activities. It is providing support on how to initiate a CBR program or how to strengthen the existing one (WHO et al., 2007).

In fact, communities are typically different in culture, political system, and socioeconomic condition, so more than one guideline models of CBR were present.

Despite this, issues covered in the guideline are of concern world wide as poverty issue, educational attainment, and access to employment.

According to WHO et al., (2007) the CBR guidelines focus primarily on the five key domains of well-being such as health, education, livelihood, social and the empowerment of people with disabilities and their families. This was illustrated in the matrix which has been developed to give a clear framework for CBR program (Annex3). The matrix represents the topic areas which an effective CBR program may contain depending on local circumstances, while it is a select and mix series of options for the CBR manager/practitioner.

There are five basic principles which the guidelines are built on. These are inclusion, participation, sustainability, empowerment, self-advocacy, and a barrier free environment. Guideline principles are overlapping depending on each other and cannot be separated. The CBR guidelines contain different experiences to promote and illustrate a practical strategy. The guidelines suggest ways to achieve these aims through community based initiatives, and inclusive development.

## 2.19 Evaluation of CBR

About evaluation of the CBR; Zhao and Kwok (2002) explained that it consists of three parts: evaluation of management in CBR, evaluation of implementation, and evaluation of social impacts.

### 2.19.1 Evaluation of Management in CBR:

Zhao and Kwok (2002) mentioned that the main duties of management are planning, organizing, allocating personnel, guiding, controlling and creating new trails. Also the management role of CBR includes policy-making, training of personnel, and implementation at all levels, provision of resources, monitoring and evaluation. Recently, rehabilitation focuses on information system as it reflects various benefits in the CBR programs. Boyce and Ballantyne (2010) talked about the advantages of information based approach to disability where it can appreciate the value in any number of rehabilitation strategies like CBR programs.

Such these advantages are: information is an unlimited resource and it can be shared different human resource so; it can be multiply through the process of feedback between

individual, groups, and systems, furthermore information is less costly other duties that's need financial resources.

Cornielje et al., (2008) mentioned that; it is important to have a management information system (MIS) to measure the results and the credibility of CBR programs, and to establish an extensive baseline data that is necessary for both well implementation and development of these programs. Baselines data applies to collect the necessary data during disabled assessment and data which must be investigate such as clients needs. This is to assist in measuring various subjects in CBR programs as, the impact of CBR on disabled people, their families, the staff performance, the income, the expenditure, and others (cornielje et al., 2008).

### 2.19.2 Evaluation of Implementation in CBR:

An effective CBR network should be provided with four functions; organization management, monitoring and evaluation, professional technique and information and statistics. The concept of rehabilitation lays stress on functional training of disabled individual, interventions in changing or adapting the environment; equalization of opportunities of disabled persons in the general system of society; and protection of human rights of disabled people. Community-based rehabilitation means the services through which all disabled people can get access to rehabilitation including health care, educational, vocational and social aspects, so as to reaching the rehabilitation goals. Four aspects should be taken into account in the evaluation of comprehensive rehabilitation services in CBR programs. Those are medical, vocational, educational, and social rehabilitation aspects.

### 2.19.3 Evaluation of Social Impacts from CBR:

One of the main purposes of CBR is to produce socially beneficial results. It calls to create a social atmosphere with equality, solidarity, integration, and dignity. An ideal CBR program should be founded on positive attitude changes (Zhao and Kwok, 2002).

Helander (1999) reviewed the evaluation and experience applied to CBR programs in his book entitled "Prejudice and Dignity-An Introduction to Community-Based Rehabilitation. He dealt with the principles of evaluation, with a review of some representative case studies which report the outcome of CBR. Helander (1999) also

pointed to five factors which must be considered in the evaluation of CBR namely relevance, effectiveness, efficiency, sustainability, and the impact of the programs.

The following paragraphs reported many studies with different aspects about the evaluation of CBR programs.

Yu et al., (2009) evaluates the effects of community-based rehabilitation in China. The study based on comparison of clinical neurological function shortage scale between two groups of stroke patients at different stages. A significant difference between the rehabilitation group and control group was found at five months as the first one show lower of neurological deficit score than the other group. Yu et al., (2009) concluded that, standardized community-based rehabilitation therapy can help stroke patients to improve their neurological function.

Another study of Legg and Langhorne (2004), who assessed the effects of therapy-based rehabilitation services targeted at stroke patients in the community, found that CBR recovers the ability to carry out person's ADL and decrease worsening risk. While Hale (2004) demonstrated that CBR was not only has important effect on stroked patients in getting appropriate results to gain functions , but also it was less costly other model of rehabilitation.

An article for Sharma (2007) titled " Evaluation In Community Based Rehabilitation Programs: A Strength Weakness, Opportunities and Threats Analysis " where the purpose of this article was to analyze qualitatively the extent to which community based rehabilitation programs have been evaluated over the past thirty years. A framework of strengths, weaknesses, opportunities, and threats analysis was used in conducting this analysis. Sharma (2007) focused on developing of new instruments for CBR evaluation. He found some of the weaknesses were: lack of consistency in outcome measures, lack of cost benefit and cost effectiveness studies, and lack of focus on other than mobility related disabilities by most projects.

El Beltajy (2003), through his study about evaluation of medical rehabilitation services offered to the physically disabled clients due to AL-Aqsa Intifada found that, there is a shortage in the rehabilitation workers, lack of community awareness about medical research centers and its services, and he suggested for developed rehabilitation centers and supply it with recreations modality. Moreover, enhance the collaboration through meeting with different ministries and beneficiaries.

According to a study carried out by Abu- Mansur, (2007) to evaluate the community based rehabilitation programs in the refugee's camps in Gaza strip that aimed to identify the level of CBR services from the beneficiaries and rehabilitation provider's perspective, and recognize the problems that faced the CBR. The study indicated that the level of the rehabilitation services is very effective, and there are no statistically significant differences between services provided to gender, while the found differences were according to the educational level, age categories and years of experience among rehabilitation providers which reach statistically significant.

In India; Moulton (1998) demonstrated the significant role of CBR in the early detection of visual disability, and prevention of blindness in South West Uganda through house to house survey of around 12.000 populations. CRWs identified 456 people with vision < count fingers at 3 meters. The rehabilitation workers assessed 371 (81%) of them are patients, and referred them directly to opthalmic clinic. It was confirmed that 300 of them with bilateral visual problems have had eye surgery.

Lang (2011) mentioned that, professionals can and should play important role in the provision of disability services in CBR programs. Lang (2011) considered it was essential for disability movement and service providers (be they government or NGOs) to enter into a constructive dialogue to ensure that any service provision actually meets the needs of disabled people, while at the same time respecting their dignity and worth.

"Home based treatment with locally available foods can be used successfully to rehabilitate severely malnourished children". This was the conclusion of a study conducted in Karachi by Akram et al., (2010). The study aimed to improve nutrition of 22 malnourished children in the community. All children under 5 years, and they were provided with high density diet which consumed in addition to daily weight, while the result was as the following: twenty two patients (91.6%) were improved by the end of 5 month. That study reflects the significant role of CBR programs to improve the individual health which considers one aspect of health promotion and it is very necessary mainly in developing countries.

In Palestine, Nilsson and Qutteina (2005) evaluated CBR programs that investigated the impact of the programs from the perspective of persons with disabilities themselves. They found that CBR programs had an exceptional impact on emotional well being and

self esteem, interpersonal relations, social inclusion and personal development. It has had some impact on physical well being, while CBR programs had limited impact on self determination and influence material well being and rights.

A study of Qutteina, (2007) about the status of children in the CBR programs in WB and GS indicated that 47% of children in CBRPs are integrated in schools and Kindergartens. In addition, CBRPs adopt inclusive social activities mainly advocacy. However, activities specifically designed to promote the rights of disabled people are much less, such as prevention and early detection activities of disability.

A study carried out by Al- Yassir (2004) who evaluates CBR programs at Baqa'a Camp in Jordan emphases on the role of the different specialists working with the CBR. Also Al- Yassir (2004) found one of strengths is that, training program includes recreational sessions. On the other hand, their is poor in the monitoring and evaluation system, lack of priority in integration and equalization of people with disability in the society and lack of staff motivation with drop out of volunteers.

Mitchell et al., (1993) conducted a study designed to determine if CBRPs develop a positive community attitudes towards people with disabilities or not. Through his study; he found that awareness training, and direct contact with people with disabilities produce positive attitudes towards disabled persons.

Achievement of the independency for disabled people considers fundamental proof for the effectiveness of CBR. A study carried out by Velema et al., (2008) aimed to identify the evidence for the effectiveness of rehabilitation in the community programs. The study based on review of different interventions by CBR programs in 22 low and middle income countries in Asia, Africa, and Central America and concluded that: at least 50% of clients have increased independency. Social inclusion, more acceptances of disables and better cope with them resulted from social process of CBR, from transfer of knowledge, and from facilitate communication. In addition, the review indicates improvement in the income of disabled persons through economic intervention of CBR (Velema et al., 2008).

It is essential to build an evidence base in CBR programs. Kuipers et al., (2008) identifies different themes through qualitative analysis of the recommendation sections of 37 CBR evaluation reports. The study was performed to explore the viability of conducting a systematic, largely qualitative synthesis of evaluation reports from CBR projects in the developing countries. They found that; management issues were the primary areas for recommendation and there is need for governmental, political, organizational and community level collaboration. On the other hand, Kuipers et al., 2008) emphasized strongly on the inclusion of technical, organizational, and personal aspects of management and strategic leadership in the future policy framework and CBR implementation.

Mannan and Turnbull (2007) reviewed the CBR evaluations for 30 journals articles using both quantitative and qualitative methods. The evaluation in these articles was from the 15 following countries: Afghanistan, Bangladesh, China, India, Indonesia, Jamaica, Lao, Nepal, Palestine, Pakistan, Philippines, South Korea, Ukraine, Vietnam, and Zimbabwe. They focus on four features of evaluation, those are: service delivery system, community involvement, transfer technology and organization, and management.
The review found that CBR is valuable for disabled people in the community, and it makes them easier for educational integration but, it failed to teach them activities of daily living in a successful manner. Further more, presence of several problems such as lack of effective training for RWs.

FinkenflugeL (1996) conducted a study that aims to explore variables which influenced the appreciation of CBR by caregivers of a child with a disability. He revealed that CBR is not just a special way of organizing rehabilitation services, but also it was a type of rehabilitation whereby caregivers are involved with, and responsible for the rehabilitation process. Moreover, FinkenflugeL (1996) found a significant relation between satisfactions with CBR and the attitude towards various health services. He stated that, satisfaction identified correlated with the evaluation of CBR by caregivers of children with a disability.

# Chapter (3)
# Methodology

This chapter presents the methodology used in this study. It begins with the study-selected design, study populations, study setting, periods of the study, sample size, eligibility criteria, and data collection. Further, it illustrates the validity and reliability of the instrument that is used for data collection. Additionally, methods of data analysis, limitation of the study and ethical matters are included.

## 3.1 Study Design

The type of this study is evaluative design that includes triangulation methods. Employment of triangulation research combining both qualitative and quantitative techniques enhances the validity and reliability of the results by comparing the data obtained from different sources. Triangulation's idea originated from a craft used by land surveyors, who increase the validity of a map by incorporating measures from different angles (Fathalla, 2004).

The study design has been selected as qualitative method used to generate knowledge that provides meaning and conceptualization about the main issues in regards to the CBR programs. At the same time, quantitative methods conducted on representative sample, and it described main items through the questionnaire which represent the input, process, and the output of CBR programs. Furthermore the design is inexpensive, and enables the researcher to meet the study objectives at a suitable time.

## 3.2 Study Population

The study population consisted of different stakeholders: beneficiaries from the CBR programs regardless of the type of disability, rehabilitation workers, supervisors of the programs, and programs managers at Palestinian Medical Relief Society and National Society for Rehabilitation in the North and Gaza governorates. In addition, medical records of persons with disability have been reviewed from each society for the study validation.

## 3.3 Sample Size

The size of the quantitative sample (beneficiaries from CBR) for this study was determined by using the statistical calculator of the EPI-INFO program. The estimated number of disabled in North and Gaza governorates was 14,334. 4674 from the North governorate and 9660 from Gaza governorate (see annex 4). The proposed sample size was 288 disabled and the researcher saw to raise those to 300 because of the expectancy of low response rate.

## 3.4 Sampling process

The sample size divided proportionally between the 2 governorates. The number from North governorate was 100 disabled, and it was 200 disabled from Gaza governorate. The beneficiaries from both societies were selected randomly.

The researcher used the currently active cases at both societies which was 400 in the PMRS and 600 in NSR and the researcher used the systematic random sample which carried out through listing all disabled names, those currently enrolled in both societies and selecting one randomly then take every 4th subject from PMRS and every 3rd one from NSR.

For key informative interview; ten subjects have been selected purposively, from each society; program's director, supervisor and three of RWs. The medical records that reviewed are twenty, 10 from each institution according to (United State Agency for International Development- USAID, 2003).

## 3.5 Study Settings

This study was carried out at the two NGOs namely; the NSR in Gaza Governorate and the PMRS in the North Governorate.

## 3.6 Period of the Study

The study started in June 2010 by conducting the administrative procedures and gaining ethical approval. A pilot study was conducted in July 2010. Data collection started in September 2010 and continued to mid November 2010. Data entry, analysis, and writing the final report continued till the end of March 2011.

## 3.7 Eligibility Criteria

### 3.7.1 Inclusion Criteria:

- Beneficiaries from the CBR programs.
- Disabled family, if the random sample be a disabled who unable to express him self.
- The directors and the supervisor of the programs of each society.
- Rehabilitation workers who are currently working at NSR and PMRS during the data collection period.

### 3.7.2 Exclusion Criteria:

- Disabled who are not enrolled in one of both societies.
- Accountants, secretaries, and drivers from both societies will be excluded.

## 3.8 Ethical and Administrative Considerations

Ethical approval from Helsinki Committee in Gaza Strip was obtained to conduct the study (Annex5). Also, an approval letters was obtained from the director of NSR society and PMRS (Annex 6 & 7). In addition, informed consent was gained from the participants including beneficiaries, supervisors and RWs with explanation of the purpose of the study and their right to optional contribution; considering confidentiality of information (Annex 8 &9).

## 3.9 Instruments of Data Collection in the Study

The researcher used 3 instruments for data collection; interviewed questionnaire for people with disability, key informant interview and reviewing of disabled's medical files. The first instrument is an interviewed questionnaire, as the form was prepared, organized, and numbered with serial numbers. It was constructed from many items that parallel to the WHO matrix of CBR and divided into categories which express the activities of the programs. Questions were arranged in a logical sequence to facilitate the data collection with a consideration to the cultural perspectives.

The main areas included in the questionnaire were the following:

- Personal and demographic data, such as gender, age, address, governorate, social status, and years of education, in addition to previous and current occupation.
- Socioeconomic information, such as monthly income.
- Disability types and causes.
- Types of the services, frequency, and period of visits.
- The role of RWs toward disabled people.
- The communication between rehabilitation staff, disabled people, and families.
- Advocacy and concern the disabled rights, opinions, and meeting disabled's needs.
- Involvement of disabled person in planning and evaluation of the rehabilitation services.
- Disabled integration within family and community.
- Social participation in events and celebrations.
- Description of the satisfaction of disabled about the services that he/she received.
- Share the beneficiaries for developing the CBR programs. Annex (10) shows the utilized questionnaire items.

The second instrument was key informant interview. It was a qualitative method by which the researcher gets information directly from knowledgeable people and explored new idea once it provided the how and what happened in the various programs steps (USAID, 1996).

The researcher formulate study questions for ten key informants at NSR and PMRS including program's directors, supervisors and six of RWs (Annex 11 & 12).
The third instrument was medical files checklist (Annex 13), in which data such as documentation, set of a plan, follow up, evaluation, and others were looked.

## 3.10 Validity and Reliability

The use of reliability and validity are common in triangulation research paradigm. Mark, (1996) defines validity as "the extent to which a measuring instrument measures what it is supposed to measure".

### 3.10.1 Quantitative part (questionnaire):

**- Reliability**

Reliability refers to the extent to which results are consistent over time. Burns and Grove (1993) described reliability as it is concerned with how consistently the measurement technique measures the concept of interest.

In this study, the following steps were done to assure instruments reliability:

- Standardizing the implementation of data collection by the researcher her self.
- Data entry by the researcher in the same day of data collection.
- Re-entry of 5% of the data after finishing data entry assures correct entry procedure and decrease entry errors.

**- Validity**

In this study, face and content validity was used through twelve different experts including researchers, evaluators and program managers to evaluate the initial research instrument. Specific information was given to them including the title of the research, objectives of the study and research questions (Annex 14).

Experts review the content of each item, as a result; slight changes to the questionnaire were added and the researcher considered all of them. List of experts names are provided in annex (15). Furthermore, review of the medical records assessed in maintaining of instrument validity.

### 3.10.2 Qualitative Part:

In this study and to maintain the trustworthiness of the qualitative part; peer check was done through experts to enrich the interview's questions, assure that they cover all dimensions and to revise the key informative interview questions when required.

Then, check representativeness of key informants was done to ensure no significant groups were overlooked. In addition, get their feedback on the major findings to assure accuracy and transparency of the transcripts.

Again, recording the interviews enhanced tracking up facts and re-checking the accuracy of the transcripts which done early and once applied of the interview. Furthermore, all the transcripts and recordings will be kept for tracking at any time.

## 3.11 Pilot Study for the Questionnaire

A piloting process was conducted before starting the data collection. The piloting process aimed to help in identifying problems in the research design, test data collection tools for validity, reliability, sensitivity and objectivity. Piloting was performed on 10 subjects from CBR beneficiaries who were selected randomly from both societies. Subjects who were selected for the pilot study were included in the study because of no significant changes to the piloting questionnaire were done, and the researcher's expectations about the response rate to be not high.

## 3.12 Response Rate

The researcher found that, twelve from the sample size were dead, so the sample returns to be (288) disabled's persons. Of them, 201 participants agreed to participate with a response rate of 69.7%, and the rest of them refused to participate in the study.

The researcher attributes this result of response to the research topic which is impressible and sensitive.

## 3.13 Data Management and Analysis

### 3.13.1 Quantitative part:

The collected data was introduced to the computer using the Statistical Package for Social Sciences (SPSS) program version 16. Data analysis was carried out through reviewing and coding of the questionnaires. Data cleaning was done through checking out a random number of the questionnaires and through exploring descriptive statistic frequencies for all variables. Defining and recoding of variables was done. Means and

standard deviations were computed for the continuous numeric variables and cross tabulation for the main findings was applied. Moreover, advanced statistical tests such as t-test and one way ANOVA test have utilized to compare means of numeric variables. In addition, Chi square tests were used to examine the statistical relationships between the categorized variables.

Related to reviewing of the medical files; quantitative analysis was applied by demonstrating the percentage of the findings.

### 3.13.2 Qualitative part:

The researcher used open coding thematic analysis method for qualitative analysis of the key informant interview. Transcripts are the basis for the analysis.

To initiate the analysis; the researcher maintained the following materials: a copy of the interview schedule, inter-actional observational remarks, copies of written notes and debriefing reports which taken immediately after each interview.

According to (USAID,1996) analysis of key informant interviews carried out through preparation of interview summary sheets in that the information is classified into themes, considered the meanings and the context of words that were spoken beside voice tone, and the animations with which the words or phrases were used.

Each transcript was read independently, at least three times, and notes were made throughout the reading on the general themes that arising from the data and relevant to the study. In addition, the researcher highlighted themes with different colors markers, continuing this process until most of the transcripts had been absorbed.

Then descriptive codes have been taken since it covers the key ideas and questions such as program's services, coverage, application of disability law, programs sustainability and others. The next step was developed of storage and retrieval system by preparing folders for each category, manual cutting of relevant comments, and pasting them onto flip chart sheets that organized according to the coding scheme, then filing them in the appropriate folder.

The researcher obtained the main findings from the transcripts of the interviews, then comparison and integration between the quantitative and the qualitative findings was done to highlight underlying issues and facts regard to the study.

## 3.14 Limitations of the Study

The support that the researcher has received from the academic supervisor and then from the CBR societies decreased the limitations that face her. However the main constraints were:

- Difficulty to access the sample in the community.

- Recurrent cutting of electricity.

- Unstable political situation.

- Lack of resources and materials about the study of concern.

# Chapter (4)

## Results and Discussion

This chapter describes the results of the study, and it presents the analysis and the discussion of the gathered data by quantitative and qualitative techniques. The result shows the characteristics and the distribution of the respondents of questionnaires from the North and Gaza governorates. In addition to that, the analysis illustrates the relationship between variables related to evaluation of CBR programs.

It is worth reminding the reader that the study sample was 300 participants from the North and Gaza governorates with 175 males and 125 females. In general, the response rate was 69.7%, and it was higher among females.

| | **Male** | **Female** | **Total** |
|---|---|---|---|
| **Sample** | 175 | 125 | 300 |
| **Respondent** | 101 | 100 | 201 |
| **Response Rate** | 57.7% | 80% | 69.7% |

## 4.1 Socio-demographic characteristics

Table 4.1 shows that, the studied population age ranges between 1-5 years, 6-18 and from 19 and above with a mean of 19.3 years. The majority of disabled's age found to be between 1-18 years (68.2%), while the age above 18 forms (31.8%).

The NSR and the PMRS (2009) reported that 42.5% from the disableds in the North are females and 57.5% are male, while females constitute 44.4% from the disableds in GG and 55.6% are male. At the same time the NSR and the PMRS (2009) in their report stated that the majority of people with disability are more than 18 years in both governorates.

The study found that there was equal distribution of male (50.2%) and female (49.8%) in the sample, and the researcher attributed this to the respondents' rate of females (80%) which is higher than in males (57.7%).

**Table (4.1): Distribution of subjects by socio-demographic characteristics**

| Characteristics | No Total (201) | % |
|---|---|---|
| **Age group** | | |
| 1-5 | 46 | 22.9 |
| 6-18 | 91 | 45.3 |
| Above 18 | 64 | 31.8 |
| **Gender** | | |
| Male | 101 | 50.2 |
| Female | 100 | 49.8 |
| **Address** | | |
| Gaza Governorate | 111 | 55.2 |
| The North Governorate | 90 | 44.8 |
| **Social Status before the Disability** | | |
| Single | 167 | 83.1 |
| Married | 34 | 16.9 |
| **Social Status after the Disability** | | |
| Single | 161 | 80.1 |
| Married | 40 | 19.9 |
| **Previous Occupation** | | |
| Child | 107 | 53.2 |
| Student | 30 | 14.9 |
| House Wife | 26 | 12.9 |
| Worker | 17 | 8.5 |
| Without Work | 15 | 7.5 |
| Employer | 6 | 3.0 |
| **Occupation after disability** | | |
| Child | 107 | 53.2 |
| Without Work | 38 | 18.9 |
| House Wife | 27 | 13.5 |
| Student | 24 | 11.9 |
| Employer | 4 | 2.0 |
| Worker | 1 | 0.5 |
| **Educational Level** | | |
| Primary | 51 | 25.4 |
| Illiterate | 49 | 24.4 |
| Secondary | 42 | 20.9 |
| Under Kindergarten Stage | 34 | 17.0 |
| Kindergarten | 19 | 9.4 |
| University | 5 | 2.4 |
| Vocational Diploma | 1 | 0.5 |
| **Family Income** | | |
| Less than 1000 | 162 | 80.6 |
| 1000-3000 | 32 | 15.9 |
| More than 3000 | 7 | 3.5 |

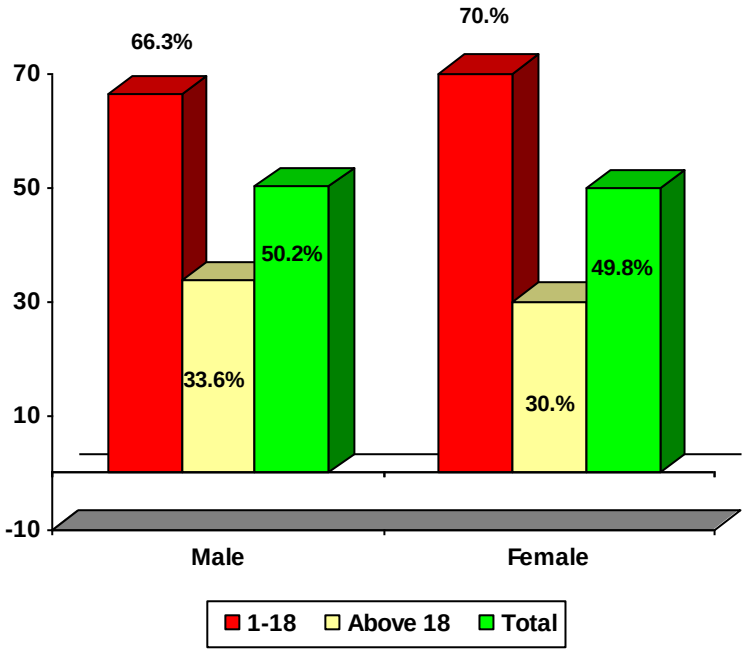



**Figure 4.1: Distribution of participants by sex and age group**

Finger 4.1 shows the study sample age group. Those under 18 years (66.3%) are male and (70%) are females, while the participants above 18 years was nearly (32%), (33.6%) are male and (30%) are female. Also, the same figure explains that there is similarity in both sexes of disabled people, as (50.2%) constitutes males and (49.8%) constitutes the females.

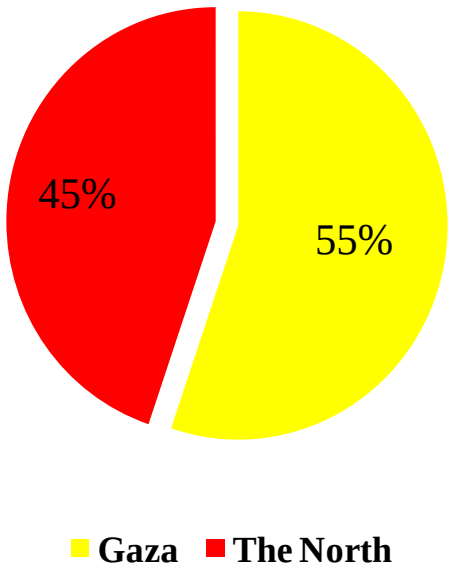



**Figure 4.2: Distribution of participants by governorate**

Figure 4.2 demonstrates the distribution of participants by governorate. In this study the participants from Gaza governorate (55.2%) are higher than those from the North Governorate (45%). We expected Gaza governorate to be double the North where the population and disableds of Gaza were twice the North.

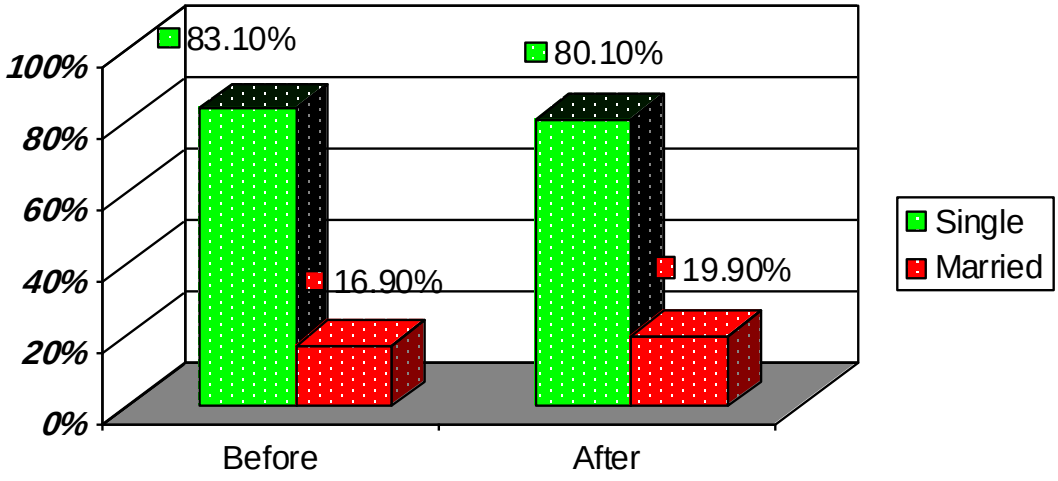



**Figure 4.3: Distribution of disabled by social status before and after the disability**

As shown in table 4.1, figure 4.3 explains that the distribution of disabled people by social status before and after the disability. Singles of disabled forms (83.1%) and (3%) of them be married since the single's rate declined to (80.1%) post disability. Regarding married, they formed (17%) of the study sample and those increased to be nearly (20%) after the occurrence of the disability. This simple rate of change indicates a good trend in the social aspect towards the disability in the community.

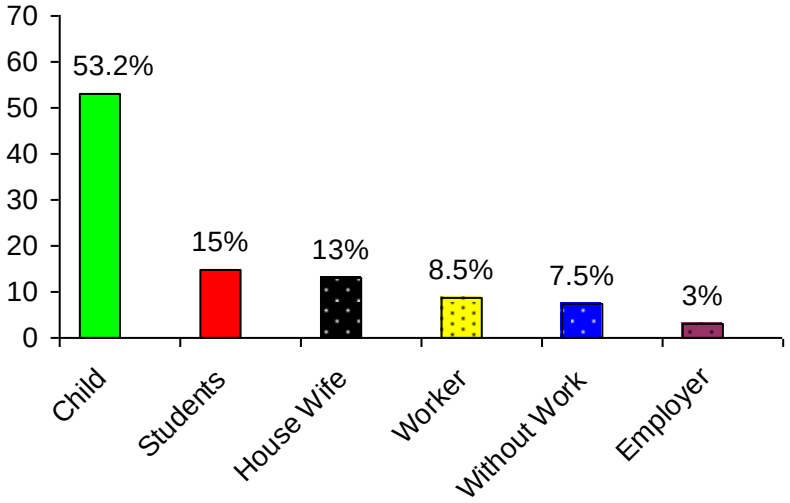



**Figure 4.4: Distribution of disabled by the previous occupation**

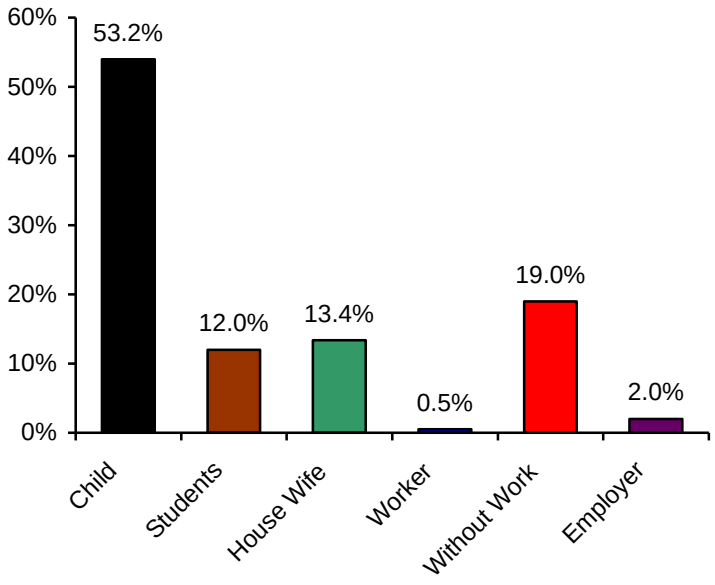



**Figure 4.5: Distribution of disabled by the occupation after the disability**

Figures 4.4 and 4.5 illustrated the occupation of the participants before and after the disability. The most prominent change of those are workers who decreased from 8.5% to 0.5%, followed by people without work, as the prevalence increased from 7.5% before disability to be 19% after it. There is an obvious decrease in students from 15% to 11.9 % after the disability.

The study result agrees with the (ILO, 2009) that many disabled persons in the developing countries access to work opportunities, training, and services are limited. Those are more likely to be unemployed or earn less than non disabled people, and be in jobs with poor promotional prospects and working conditions.

The researcher thinks that disability regardless of its type losses the person the ability for work and subsequently increases the burden of joblessness. At the same time, she saw this issue link with different factors such as the budget of the CBRPs, and the lived poverty situation.

Regarding the educational level of the participants, the mean years of education was 2.67 years (SD 1.32, range 5). Figure 4.6 illustrates the distribution of the participants by the level of education.

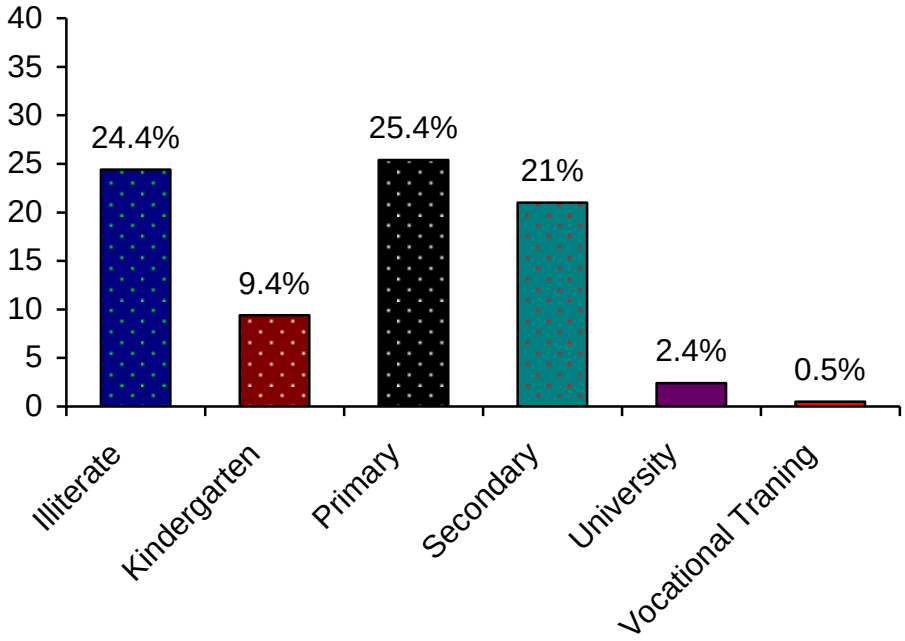



**Figure 4.6: Distribution of disabled people by the level of education**

As shown in figure 4.6, the primary educational level (25.4%) was the highest one, followed by illiterate that forms (24.4%), while secondary stage composed (21%), and kindergarten has (9.4%). University educational level was (2.4%) at the moment more than 60% of the participants are below the university level. Vocational training formed (0.5%) only.

The above results demonstrates that there is a low chance of disabled people in education sector, and it mirrors the validity of truth that people with disabilities suffer from exclusive education and vulnerability in different stages. Also, the study results was parallel to UNESCO estimation that 90% of children with disabilities in the developing countries do not attend schools while there are 75 million children of primary school age who are out of school and one third of them are children with disabilities (UNESCO, 2010).

Concerning the financial status of disabled people, the monthly family's income is less than 1000 New Israeli Shekel (NIS) was (80.6%), while it was nearly (16%) for those whose monthly family income is between 1000-3000 NIS and (3.5%) presents disabled whose income is more than 3000 NIS monthly. Based on the estimation of (PCBS, 2009), the poverty line was 2,278 NIS (581 US $), while the deep poverty line was 1,870

NIS (477 US $). The study indicated that the greater part is equal to (81%) of persons with disability suffer from deep poverty line. The researcher referred that to the strong correlation between poverty and disability as stated by (WHO, 2006a), in addition to the economical stressors on GS, crisis and to the low Palestinian family income.

## 4.2 Disability

**Table (4.2): Classification of disability by causes and types in Gaza and North Gaza governorates**

| Characteristics | No | Total (201) | % |
|---|---|---|---|
| **Cause** | | | |
| Congenital | 57 | | 28.4 |
| Acquired | 144 | | 71.6 |
| **Reasons of Acquired Disability** | | | |
| Accidents | 75 | | 52.1 |
| Communicable Diseases | 24 | | 16.7 |
| War | 21 | | 14.6 |
| Non communicable diseases | 9 | | 6.2 |
| Others | 15 | | 10.4 |
| **Classification of Accidents** | | | |
| Birth Accidents | 36 | | 48 |
| CVA | 16 | | 21.3 |
| Falling Down | 14 | | 18.7 |
| Others | 9 | | 12 |
| **Types** | | | |
| Physical | 153 | | 76.1 |
| Visual | 20 | | 10.0 |
| Strange Behavior | 15 | | 7.5 |
| Hearing | 10 | | 5.0 |
| Convulsion | 3 | | 1.5 |
| **Multiple Disability** | | | |
| Yes | 53 | | 26.4 |
| No | 148 | | 73.6 |

Table 4.2 shows that, the majority of disability caused by acquired reasons and formed (71.6%), while congenital disability represented (28.4%). There are (26.4%) who have more than one type of disability as a physical with convulsion, or speech associated with strange behavior. Disability is a burden for Palestinian people, and the war increased this burden, where the war is a direct cause of the disability, and responsible in this study for 14.6% of acquired causes. Accidents are the common reasons of acquired disability which represents (52.1%), that is followed by communicable diseases that forms (16.7%)

as meningitis or encephalitis. Others, like idiopathic causes and senility contribute to (10.4%), and the least was a non communicable disease (6.2%).

Regarding the classification of accidents, birth accident including oxygen deficiency, brachial plexus lesion like Erb's palsy has the highest rate which is about (48%). Those require reviewing the preventable causes that reflects the need of prenatal care, natal and post natal care. At the same time, Cerebro Vascular Accident (CVA) represented (21.3%) and falling down (18.7%), while other causes like road traffic accident, rickets formed (12%) of the accidental disability caused by acquired reasons.

All key informants had consensus that they have dealt with all types of disability, regardless of the sex, age and if the disabled was citizen or refugee.

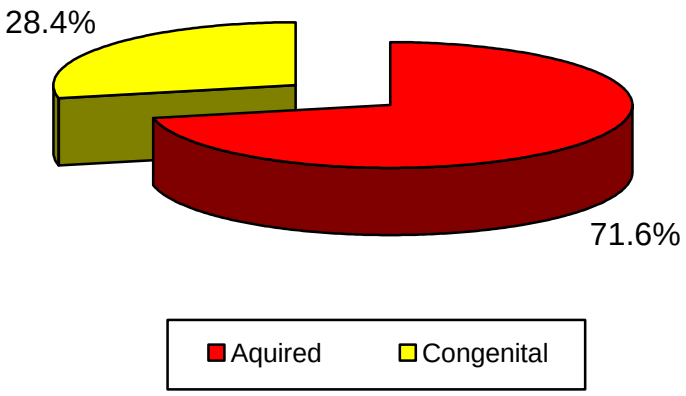



**Figure 4.7: Distribution of disability by causes**

The research result showed that (76.1%) of the participants are physically disable, followed by the visual impairment that composed (10.0%). These results are similar to the (PCBS, 2007) as physical disability is the highest one in GS which is about (1.2%) followed by visual impairment which is (0.48%). Strange behavior (mental retardation) formed (7.5%), and the least one was convulsion which formed (1.5%).

The results of this study is consistent with Singal (2008) who stated that, many factors contributes to acquiring impairment or disability in the developing countries such as infectious diseases, malnutrition, accidents and injuries, except poor immunization which is not the cause in Gaza, where it is characterized with good coverage. At the same time, these results are not similar to the facts by CDC (2008), which indicated that chronic diseases such as heart disease, stroke, cancer, and arthritis are the primary, costly, and

preventable of all health problems in the U.S., while diabetes continues to be the leading cause of no traumatic lower extremity amputations, kidney failure, and blindness among adults. Since in this study, accidents, communicable diseases and the war are the most causative variables of the disability.

**Table 4.3: Cross tabulation of disability types and disabled age group**

| Disability type | Age group | | | Total |
|---|---|---|---|---|
| | 1-5 | 6-18 | 19 and more | |
| Physical | 35 | 63 | 55 | 153 |
| Visual | 1 | 11 | 8 | 20 |
| Strange behavior | 4 | 10 | 1 | 15 |
| Hearing | 4 | 6 | 0 | 10 |
| Convulsion | 2 | 1 | 0 | 3 |
| Total | 46 | 91 | 64 | 201 |

It appears from table 4.3 that most of the study population are below 18 years (68.2%), and the majority of them (76.1%) has Physical disability, followed by visual type that forms (10%). Strange behavior or mental retardation forms (7.5%), while the lowest was convulsion (1.5%). In this study, it was predictable that physical disability has the highest type due to the political state, and the existing motorcycle phenomena that causes several accidents.

## 4.3 Different services provided through CBR programs

Table 4.4 shows the provided services through CBR programs to disabled people who participated in the study. It is important to know that beneficiaries from CBR programs may utilize more than one type of services at the same time. The most prominent of the introduced services were relief aids (42.8%) which include disposables, food basket, and clothes. Assistive devices like crutches, wheelchairs, prosthetics, orthopedic appliances, and air mattress formed (28.6%), while physiotherapy and psychological therapy were nearly equal constituting (27%). Referral to other institutions for rehabilitation composed (28.8%), and provision of health education and awareness formed (9%). It appears that, the supply of medical services, occupational therapy and environmental adaptation was approximately equal to (3.5%), the financial assistance forms (1.9%), while speech

therapy and educational integration was (1.5%). The least provided type of those services is vocational training and employment which forms only (0.5%).

Also, table 4.4 illustrated that (73%) of the participants received rehabilitation services through home visits, and (69.5%) of them via rehabilitation's team.

researcher show that the type of services which provided by CBRPs in this study concentrated on health, educational, and social domains rather than empowerment and livelihood activities as revealed by the matrix of WHO et al., (2007), and perhaps due to the limited budget of the programs or because of the majority of the study sample aged less than 18 years.

**Table 4.4: Type of services provided to the study participants in Gaza and North Gaza governorates**

| Characteristics | No | % |
|---|---|---|
| **Types** | | |
| Relief Aids | 86 | 42.8 |
| Assistive Devices | 57 | 28.6 |
| Physiotherapy | 54 | 27.1 |
| Psychosocial Support | 53 | 26.3 |
| Referral | 58 | 28.8 |
| Health Education & Awareness | 18 | 9 |
| Supply of Medical Services | 8 | 3.9 |
| Occupational Therapy | 7 | 3.5 |
| Environmental Adaptation | 6 | 3 |
| Financial | 4 | 1.9 |
| Speech Therapy | 3 | 1.5 |
| Educational Integration | 3 | 1.5 |
| Vocational Training | 1 | 0.5 |
| Employment | 1 | 0.5 |
| **Home Visits** | | |
| Yes | 147 | 73 |
| No | 54 | 27 |
| **CBR services through a team** | | |
| Yes | 102 | 69.5 |
| Sometimes | 27 | 18.3 |
| No | 18 | 12.2 |
| Total | 147 | 100.0 |
| **Number of Visits** | | |
| 1 time | 39 | 26.5 |
| < 1 time | 74 | 50.3 |
| > 1 time | 34 | 23.2 |
| **Fees for Services** | | |
| Yes | 1 | 0.5 |
| No | 200 | 99.5 |

The researcher attributed to have relief aids by the greater portion (42.8%) to the massive needs of the disabled persons within his/her disability, and the current difficult socioeconomic condition. One the other hand, the researcher believe that it is logical that assistive devices, physiotherapy and psychosocial support nearly equal because the physical disability is the highest one, and the psychosocial support is required for all types of the disability.

However, most of the key informants believed that, their work is based on the WHO criteria, and it contained several components. Those are: disabled persons, his/her family, local institutions and the community. Furthermore, it includes specific and broad services such as screening of the disability, and health, social and educational services.
Key informants told us that program's health services include various items such as physiotherapy, occupational therapy, health education, prevention and early detection of the disability. Also it includes nursing tasks, psychological support, assistive devices, referral to other institutions as Palestine Children's Relief Fund, and others.

Related to the vocational training, the director of NSR said:" *recently, from 2010 we tend to vocational training courses for both male and female inside the society as; computer, radio and jawal repair, International Computer Driving License* (ICDL*) and multimedia. Also, we selected numbers of them for training on project management, preparing them to be access to private projects through fund resources".*

The study results were similar to the results of Diakonia/NAD (2009), which evaluated CBRPs in the Occupied Palestinian Territories, Jordan and Lebanon. It was found that within CBR the main focus has been on access to health and education, while there has been a weaker focus on implementing of further parts of the CBR matrix like livelihoods, empowerment, and social rights.
In regard to the low rate of employment and vocational training of people with disability, the study result is consistent with the literature since spending on active labour market programs constitute only 4-7% of the total spending on disability, and it still less than this in many countries (Organisation for Economic Co-operation and Development - OECD, 2009).

About the frequency of visits, our study revealed that (50.3%) of CBR beneficiaries received services by less than one visit monthly, while (26.5%) received it monthly, and (23.2%) obtained more than one visit per month. Furthermore, there is no schedule for visiting selected cases has been observed during review of the disabled's medical records. The researcher believe there is needed to arrange the home visits for disabled people as the CBR based on the community, while this is necessary to maintain the RWs trust and commitment.

Some key informants attributed the low frequency of visits to the work's nature. They said:" *if the aim of visit was to follow up the disabled; visits were far but, if we work with him; visits were recurrent at least to more than 3 times monthly*".

These results translate the lack of consistency and structure of visits, and it was contrast to Reimer and Lenavenec, (2005) who confirmed on the success of CBR programs through provision of services three hours or more a week of particular clients in their community.

## Table 4.5: Differences of the CBR services mean scores by governorate

| Governorate | Number | Mean | Std. Deviation | t-test | P-value |
|---|---|---|---|---|---|
| Gaza | 111 | 1.21 | 0.878 | -6.39 | 0.001* |
| North | 90 | 2.13 | 1.153 | | |

* Statistically significant (P-value < 0.05)

Concerning the services (dependant variable) which have been received through the CBR programs in Gaza and the North governorates, and by using t test; table 4.5 illustrated that the mean scores of services in the North was higher than GG. The difference between both means was statistically significant (P- value =0.001). The researcher attributed this result to the disabled's number in the North which is half GG number.

Related to CBR coverage, the director of NSR said that: our services cover 75% from Gaza strip except the North and east Kan-Younis area", while the director of PMRS said that: in the North; CBR programs covers 60% of the disabled people.
This considered rational coverage as WHO (1981) stated that 70% of people with disabilities helped at the community level, while the remaining with severe and multiple disabilities require specialist interventions that are not available in the community.

## Table 4.6: Differences of CBR services scores by sex

| Sex | Number | Mean | Std. Deviation | t-test | P-value |
|---|---|---|---|---|---|
| Male | 101 | 1.68 | 1.06 | 0.724 | 0.470 |
| Female | 100 | 1.57 | 1.14 | | |

As shown in table 4.6, the mean of CBR services scores for male and female is equal. t-test revealed that there is no statistically significant between services provided to both males and females (t-test 0.724, P value 0.470). This result was consistent with what had been found of a study conducted by Abu - Mansur, (2007) who evaluated the CBR programs in the refugee's camps in Gaza by which there are no differences in introducing the CBR services for both males and females.

## 4.4 CBR and Multisectoral Collaboration

Table 4.7 summarizes the results of the study about multisectoral collaboration as an important part between the CBR and other sectors. There are (28.8%) of the study population referred to other institutions. It was found that, the greater part of the referred population (41.4%) referred to NGOs, whereas (31%) referred to the private sector, in the moment that CBR share in the costs of the care.

For governmental institutions like Eyes hospital in Gaza, the disabled who referred was (17.2%), but (10.3%) referred to the international sector such as UNRWA, MSF, and there are (86.2%) noticeable collaboration between these institutions.

All key informants have the same opinion that CBR programs can not establish alone, because it needs large and continuous costs. The programs can't be successful and

sustainable without multisectoral collaboration of national and international institutions as MOH, Education, Social Affairs, Handicapped Union, UNRWA, , DPOs, the community and others.

**Table 4.7: Multisectoral Collaboration with the CBR programs**

| Characteristics | No | % |
|---|---|---|
| **Referral to Other Institutions** | | |
| Yes | 58 | 28.8 |
| No | 143 | 71.2 |
| **Institutional Name** | | |
| NGOs | 24 | 41.4 |
| Privet | 18 | 31 |
| Governmental | 10 | 17.2 |
| International | 6 | 10.3 |
| Total | 58 | 100.0 |
| **collaboration from these Institutions** | | |
| Yes | 50 | 86.2 |
| Sometimes | 6 | 10.3 |
| No | 2 | 3.4 |
| Total | 58 | 100.0 |
| **services from other rehabilitation institutions** | | |
| Yes | 89 | 44.3 |
| No | 112 | 55.7 |
| **Reason to seek services from other institutions** | | |
| More Services | 69 | 77.5 |
| Sufficient Professionals | 15 | 16.9 |
| Drugs | 3 | 3.4 |
| Without Justification | 2 | 2.2 |

At the same time, one of key informant said:" *el-hokomat mish gadra tgati ehtiajat el moaq*". That means, governments cannot cover the disable needs, so they can't work individually without collaborative efforts.

The results of the study reflect a good cooperation of national NGOs with CBR programs. In addition, it indicates weak support from governmental and international institutions. This result was similar to the finding of a study that hold in South Korea by Kim and Jo, (1999) that indicated one of the major weaknesses of implementing CBR is the lack of support from centralized government. This thing presents a shortage in the coordination and cooperation which may be a difficult barrier to overcome.

In addition, table 4.7 shows the beneficiaries who received services from other rehabilitation institutions constituted (44.3%) of the respondents. The highest one seeking more services (77.5%) in these institutions, and the researcher attributed that to the need of different services, especially that there were two or more persons with disability in the same family. There are (17%) of disabled seeks services because of sufficient professionals at other organizations. (3.4%) for drugs, while (2.2%) are seeking services without justification.

The key informants believed that CBR programs based on referral to other institutions for more services and specialties for disabled people such as, Right to Live Society for Down syndrome and Autism, Eyes hospital in Gaza for visual difficulties, Physically Handicapped People Society for physical disability, and the Jordan hospital; for diagnosis and treatment, Atfaluna Society for Deaf Children, and others.

## 4.5 Characteristics of the CBR Institutions

**Table 4.8: Physical & Psychological environmental adaptation**

| Characteristics | No | % |
|---|---|---|
| **Visit the society** | | |
| Yes | 184 | 91.5 |
| No | 17 | 8.5 |
| **difficulties to access the society** | | |
| Yes | 62 | 33.7 |
| Sometimes | 8 | 4.3 |
| No | 114 | 62.0 |
| Total | 184 | 100.0 |
| **Source of difficulties** | | |
| Transportation | 39 | 55.7 |
| Financial Issues | 21 | 30.0 |
| Unclear Address | 10 | 14.3 |
| Total | 70 | 100.0 |
| **Environmental adaptation of the institution** | | |
| Yes | 133 | 72.3 |
| Yes, to some extent | 39 | 21.2 |
| No | 12 | 6.5 |
| Total | 184 | 100.0 |
| **Provision of recreation activities** | | |
| Yes | 59 | 32.1 |
| No | 119 | 64.7 |
| Don't Know | 6 | 3.3 |
| Total | 184 | 100.0 |

Table 4.8 shows the characteristics of CBR institution, there are (91.5%) of the study population visit the society. To access the society; there are (38%) of the institutional visitors found difficulties and (62%) without any complexity. The mainly source of difficulties to access the society was the transportation (55.7%), then lacks of finance to reach the rehabilitation institution (30%), but unclear address formed (14.3%).

This expressed by different variables like far distances of the disables residency, troubles in holding the disabled child to the physiotherapy center, and poor families. Regarding to the environmental adaptation of the society, (72.3%) of the study population stated that there was adaptation, and (21.2%) stated it to some extent, other than (6.5%) demonstrated there wasn't any sign of adaptation.

About recreation activities in the society, most of visitors (64.7%) said there is no recreation activities, and (32%) stated that recreation activities was held such as journeys and summer camps, but (3.3%) don't know if there is recreation activities or not. Handicap international (2004) demonstrated the importance of sports and recreation as it have a profound effect on disabled persons' recovery and reintegration into their families and communities.

## 4.6 Performance of the Rehabilitation Workers

Table 4.9 shows the responsibility of rehabilitation workers toward disabled people in CBR programs. There are (59.2%) of the study participants demonstrated the task of RWs as good, (27.9%) as moderate, (8%) don't know and (5%) expressed them as bad.

**Table 4.9: Performance of RWs from beneficiaries' perspective**

| Characteristics | No | % |
|---|---|---|
| **Explanation about disabled condition** | | |
| Yes | 101 | 50.2 |
| No | 100 | 49.8 |
| **listen to disabled questions** | | |
| Yes | 185 | 92.0 |
| No | 16 | 8.0 |
| **RWs answer your questions** | | |
| Yes | 183 | 91.0 |
| No | 18 | 9.0 |
| **RWs promise to visit, but they didn't come** | | |
| Yes | 20 | 10.9 |

**Table 4.9: Performance of RWs from beneficiaries' perspective (cont.)**

| Characteristics | No | % |
|---|---|---|
| No | 164 | 89.1 |
| Total | 184 | 100.0 |
| **The recurrence of ignore** | | |
| once | 12 | 60.0 |
| Two time | 6 | 30.0 |
| 3 | 2 | 10.0 |
| Total | 20 | 100.0 |
| **Spend enough time during the visit** | | |
| Yes | **1**40 | 69.7 |
| No | 61 | 30.3 |
| **RWs inform you about your rehabilitation plan** | | |
| Yes | 122 | 60.7 |
| No | 79 | 39.3 |
| **RW offer feedback for you** | | |
| Yes | 78 | 38.8 |
| No | 123 | 61.2 |
| **RWs respect you** | | |
| Yes | 198 | 98.5 |
| No | 3 | 1.5 |
| **RWs guide you to prevent problems** | | |
| Yes | 131 | 65.2 |
| No | 70 | 34.8 |
| **Your expression about RWs tasks** | | |
| Good | 119 | 59.2 |
| Moderate | 56 | 27.8 |
| Bad | 10 | 5.0 |
| Don't Know | 16 | 8.0 |

**Table 4.10: Description of rehabilitation worker's performance**

| Score | Number | Percent | Result |
|---|---|---|---|
| **1-3** | **35** | **17.5** | **Bad** |
| **4-6** | **75** | **37.3** | **Moderate** |
| **7-9** | **91** | **45.3** | **Good** |

The researcher classified the RW's performance scores which has 9 degrees into 3 levels to help in judging on their performance. Those are good, moderate and bad. At the same time, the researcher considered the following: scores until 3 = bad, scores until 6=

moderate, above 6= good. As obvious in table 4.10, there are (45.3%) of RW's performance have good scores, (37.3%) were moderate, and (17.5%) have bad scores.

About RW's performance; one of key informants said:" *during the rehabilitation process; we invest the residual abilities of the disabled"*. Another one said: "*the RW was active and effective; this was through services that aiming to reach the disabled person to the highest degree of independency in his/her community"*.

Furthermore, the majority of key informants confirmed on the role of CBR programs in inclusive education as they act on integration of the disabled including all educational stages starting from kindergarten until the university according to the disabled's needs, in addition to the integration in other rehabilitation societies. At the same time, Physical environmental adaptation of schools to be suitable and comfortable besides offering the transportation from home to schools and vice versa is also considered.

Regarding the educational stages of key informants, the researcher found that 60% of key informants have a university degree or higher, while the rest have diploma. The majority of them have more than 8 years of experience, beside the different training courses in the CBR field.

Again, we found that most key informants have a positive attitude towards their profession, cooperative and interpersonal relations among the management and people with disability. Thus, it was expected to be characterized with good performance.

**Table 4.11.1: The relationship between visit's frequency and RW's performance score**

| Visits Group | Mean | SD | F | P-value |
|---|---|---|---|---|
| **1** | 6.18 | 1.76 | 4.92 | 0.009* |
| **2** | 5.88 | 1.88 | | |
| **3** | 7.12 | 1.09 | | |

* Statistically significant

The researcher categorizes the frequency of visits per month into 3 groups, those are: 1= one visit, 2= less than one visit and 3= more than one visit.

By utilizing One-Way ANOVA; table 4.11.1 shows that the third group has a higher mean of performance scores than other groups. The difference between groups was statistically significant (P- value 0.009). This means that the maximum home visits had more performance.

**Table 4.11.2: Scheffe test for visits frequency and RW's performance score**

| Visits Frequency | Mean Difference | Std. Error | Sig. | 95% Confidence Interval | |
|---|---|---|---|---|---|
| | | | | Lower Bound | Upper Bound |
| 1-2 | .247 | .338 | .767 | -.591 | 1.085 |
| 1-3 | -.849 | .398 | .107 | -1.83 | .137 |
| 2-3 | -1.096 | .351 | .009 | -1.96 | -.221 |

By applying Post Hoc test (Scheffe); table 4.11.2 demonstrated that, there are differences between visits group 2 and 3, which was statistically significance (P value 0.009). Meaning that, the difference between visits frequency even < or > one time monthly affects the work outcome. For this issue, visits more than one time monthly should be considered to maintain better performance and then good results.

**Table 4.12: The relationship between RW's performance score and disabled's independency**

| Independent by RWs | Mean | SD | t-test | P-value |
|---|---|---|---|---|
| Yes | 6.53 | 1.780 | 4.66 | 0.001* |
| No | 5.19 | 2.184 | | |

* Statistically significant

Table 4.12 presents the relation between RW's performance and disabled independency. The mean of RW's performance toward those how became independent was higher than those who are not. The results show that there was statistically significant difference (t-test 4.66, P-value 0.001). This demonstrates that RWs assess disabled persons to overcome difficulties, and to be independent as possible. In other word, the result

reflects a positive view of the CBR programs through various services that rise from disabled ability.

## 4.7 Management in the CBR programs

Table 4.13 illustrates the involvement of disabled people and their families in setting of the rehabilitation plan, follow up and evaluation. It shows that only (35.8%) of participants were shared in setting of their plan, while (64.2%) were not involved. At the same time, (84.6%) received the services through documented work and 15.4% without documentation. Regarding to follow up, nearly (55%) from the study population are followed up by the rehabilitation workers and (45.3%) shows there is no follow up.

**Table 4.13: Perception of the beneficiaries about CBR management**

| Characteristics | No | % |
|---|---|---|
| **Involvement in setting of disabled rehabilitation plan** | | |
| Yes | 72 | 35.8 |
| No | 129 | 64.2 |
| **Rehabilitation implemented through documented work** | | |
| Yes | 170 | 84.6 |
| No | 31 | 15.4 |
| **RWs follow up your condition** | | |
| Yes | 110 | 54.7 |
| No | 91 | 45.3 |
| **Involvement in the evaluation plan** | | |
| Yes | 21 | 10.4 |
| Sometimes | 21 | 10.4 |
| No | 159 | 79.1 |
| **Frequency of evaluation** | | |
| Don't Know | 16 | 38.1 |
| Every 3 month | 13 | 31.0 |
| Every 6 month | 7 | 16.7 |
| Annual | 6 | 14.3 |
| Total | 42 | 100.0 |

Also, clearly seen in table 4.13 there are (79.1%) of participants show there is no evaluation of the rehabilitation process. While those who show the applying of evaluation whether usually or sometimes is equal (10.4%). At the same time, (38.1%) of disabled people who involved in the evaluation process don't know its frequency, and

(31%) shows the evaluation was run every 3 months, while (16.7%) stated it was run every 6 months and (14.3%) demonstrated that evaluation was run annually.

With regard to developing of a rehabilitation plan, 80% of key informants stated that: "*the work is divided into two types. Firstly is the follow up, such as the need to eye glasses; such this case we don't set a plan, jus supply the disabled with the service, and follow up it. Secondly is the work case which needs a plan with short and long terms objectives and by the family assistant, and then follow up the case"*.

At the same time, the director of NSR believed that they share the disabled person in developing the plan by asking the disableds or the mothers about his/her needs through regular meeting or by home visits. Furthermore, most of key informant said that: "*every visit I hold; follow up of the disabled status was considered"*.

Although study findings revealed the documentation particularly the home visits, it also reflected that involvement and participation of persons with disability and their families in the design and implementation of the programs activities is not exist. Moreover, there was lacking of the evaluation process. This finding was consistent with a study carried out by Al- Yassir (2004) who evaluated CBR programs at Baqa'a camp in Jordan and found that there is deficiency in the follow up and evaluation process.

Regard to the program's sustainability, some of RWs think that, developing of a local committee by group from the society whom hold the volunteerism spirit can help the CBR staff, and continue with the disabled if the project was ended. While few of RWs said: *"we are ready to work as volunteers to keep the programs sustainable if donations are stopped"*. At the same time, one of them said: *"this is the responsibility of the program's director".*

The director of NSR society said: *"the sustainability of our programs referred to many factors as: sponsor's trust with the program's validity, coalition with other institutions like the Islamic relief, and welfare association, also the cooperation with other societies, and from the NSR itself where it has a large gathering place that used for different events as a resource of sustainability*".

The researcher perceived that CBR program's sustainability still threatened, and involvement of disableds, their families and the community is necessary to keep its sustainability, while steps are still needed to create the sense and ownership with CBRPs.

## 4.8 Review of the Medical Files

Medical files are essential part of health information system. It helps care providers to deliver organized health services to individuals in a facility or through activities in the community (WHO, 2008). By reviewing of a random sample of disabled's medical files in both NSR and PMR societies that provided the CBR programs in Gaza & the North governorates some facts were extracted. Table (4.14) demonstrated positive and negative points related to that subject. It was a positive point that every one of beneficiaries has a medical file containing the essential personal components like complete filling of the name, identification number, age, telephone, and the disability type.

### Table (4.14) Checklist of Medical Files

| Item | Type of filling | | | | | |
|---|---|---|---|---|---|---|
| | Complete filling | | Partial filling | | Not filling | |
| | No | % | No | % | No | % |
| **Identification** | 20 | 100 | 0 | 0 | 0 | 0 |
| **Age** | 20 | 100 | 0 | 0 | 0 | 0 |
| **Telephone** | 20 | 100 | 0 | 0 | 0 | 0 |
| **Address** | 7 | 35 | 13 | 65 | 0 | 0 |
| **Disability Type** | 19 | 95 | 0 | 0 | 1 | 5 |
| **Date of received services** | 17 | 85 | 0 | 0 | 3 | 15 |
| **Lab, Imaging Reports** | 16 | 80 | 1 | 5 | 3 | 15 |
| **Assessment** | 17 | 85 | 2 | 10 | 1 | 5 |
| **Setting of Plan** | 1 | 5 | 4 | 20 | 15 | 75 |
| **Documentation of visits** | 13 | 65 | 5 | 25 | 2 | 10 |
| **Follow Up** | 12 | 60 | 6 | 30 | 2 | 10 |
| **Evaluation** | 1 | 5 | 6 | 30 | 13 | 65 |
| **Staff signature** | 13 | 65 | 5 | 25 | 2 | 10 |

In contrast, there are some negative points, such as recording of the address where 56% of the files filling partially, and lacks the number or the name of the street that is essential for RWs where their work is based on the community arrival.

In addition, there was shortage in the documentation of some data, where 15 % of files lack the date of services received. The same percentage related to the radiological studies like X ray, ultrasonography or imaging reports like Computerized Tomography (CT), or magnetic resonance imaging (MRI) that is not reported in the file. There are 85 % of files have a complete assessment through a specific form and 10 % are filling partially, while 5% without assessment.

Planning for the rehabilitation process is important, it develops a system by which the RWs were guided, and the hoped goals can be achieved. There are 75 % of the files missed a plan, 20% done partially; containing short or long term objectives. While 5 % only was planned completely. However, documentation of visits reflects the follow up process, for this reason; they are combined together. Approximately 60 % of the medical files have complete documentation of follow up while 10 % ignore this procedure.

The researcher found that the utilized form for the assessment and evaluation by CRWs mostly includes home visits carried out by staff for initial assessment and follow up, rather than an evaluative tool which contains inputs and outputs indicators that clarify the intervention's outcome.

In fact; progress evaluation process was poor as 65 % from the files have no information about the evaluation, while only 5% of files contain it completely.

In regard to the staff signature which express the follow up and evaluation procedures, and hold the responsibility of RWs about the case progress or deterioration, it was noticeable that 25% of files have the first name, while 10% of files show neglecting of the signature.

The researcher noticed that although the presence of data base that contains disabled people numbers, and facilitate reports extraction, the available data in medical records is inadequate to give comprehensive description about essential data about disability and the rehabilitation. This is necessary to be found in the health information system, the thing that must be considered and have more awareness.

## 4.9 CBR Influence Disabled's Knowledge, Attitude and Practice (KAP)

### 4.9.1 Increase the knowledge about disability issues through the CBR:

As shown in table 4.15, there are (40.3%) known about CBR from the program's staff, (26.9%) know about it from friends, and from neighbors there are (12.9%). (11.4%) known from other institutions as Eyes hospital in Gaza, and from schools, and (8.5%) know about it from disabled people. Regarding the (CBR) itself, there are (88.6%) from beneficiaries who don't know about the program goals or resources, just they know the name of the society that provide CBR services, while (94.5%) don't know the disability law or its components.

About recognition of the complication that may affect the disabled, (56.7%) recognize and know how to prevent these complications, but (43.3%) are not aware and don't know how to prevent that complication.

Table 4.15 revealed that CBR is active in surveyed people with disabilities, and in provision of counseling and health education of disableds and their families, but also it reflected that people with disabilities not aware with different context of CBR programs and not familiar with their rights too.

Most of key informants consider the disables rights are very essential to be known and obtained as any normal person. They think many efforts must be intensive and collaborative for disabled's right advocacy, mainly employment of 5% from the disables which consider the most complex issue.

The director of NSR said: "*developing in some items of disability law was obtained such as inclusive education, but we hope to apply other matters mainly increase the services package and employment concern".*

In the same subject, the director of PMRS said:" *disability law is defective, and this is attributed to different reasons such as the fragility of disability unions. Despite the presence of 55 rehabilitation societies; approximately 12 only are active. Also, lacks of the disability concept from the decision makers, siege and the political situation between Gaza and west bank, and absent of disabled's role themselves constrains the application of disability law".*

It appears that, people with disability were usually limited to attending social events rather than having actual active participation. They don't recognize their rights well.

## Table 4.15: Effect of CBR on KAP

| Characteristics | No | % |
|---|---|---|
| **Source of knowledge about CBR programs** | | |
| CBR Staff | 81 | 40.3 |
| Friends | 54 | 26.9 |
| Neighbors | 26 | 12.9 |
| Other Institutions | 23 | 11.4 |
| Disabled People | 17 | 8.5 |
| **knowledge about this programs** | | |
| Yes | 23 | 11.4 |
| No | 178 | 88.6 |
| **knowledge about the disabled law** | | |
| Yes | 11 | 5.5 |
| No | 190 | 94.5 |
| **Recognize the complications that may affect you** | | |
| Yes | 114 | 56.7 |
| No | 87 | 43.3 |
| **know how to prevent these complications** | | |
| Yes | 115 | 57.2 |
| No | 86 | 42.8 |
| **Are you integrated with your family** | | |
| Yes | 120 | 59.7 |
| Yes, to some extent | 58 | 28.9 |
| No | 23 | 11.4 |
| **Describe your current interaction with your relatives, friends** | | |
| Good | 95 | 47.3 |
| Moderate | 70 | 34.8 |
| Bad | 36 | 17.9 |
| **Do you participate in social events** | | |
| Yes | 106 | 52.7 |
| To some extent | 52 | 25.9 |
| No | 43 | 21.4 |
| **Do you participate in celebrations that hold in the society** | | |
| Yes | 91 | 45.3 |
| Yes, to some extent | 39 | 19.4 |
| No | 71 | 35.3 |
| **Do you inform others about your disability** | | |
| Yes | 123 | 61.2 |
| Some times | 32 | 15.9 |
| No | 46 | 22.9 |
| **Practically, you deal better with daily living activities** | | |
| Yes | 123 | 61.2 |
| No | 78 | 38.8 |
| **You can adopt with disability now** | | |
| Better | 113 | 56.2 |
| The Same | 84 | 41.8 |
| Worse | 4 | 2.0 |

Furthermore, disability law which approved in (1999) is not applicable mainly employment issue. The researcher see this need hard work from the CBR team to maintain communication with other sectors mainly government, and it requires empowering people with disabilities through enhance DPOs to identify and gain their rights.

### 4.9.2 CBR enhance the disabled's positive attitude in the community:

Table 4.15 shows that the integration of disabled within the family constitutes (88.6%), and (11.4%) are not. There are (47.3%) from the study population described their interaction with their friends and relatives as good, but (18%) have bad interaction with their relatives. Concerning their participation in social events (78.6%) are shared and (21.4%) are not. Also for the contribution in celebrations that holds in the society; (45.3%) are participating, and (19.4%) are sharing to some extent, and (35.3%) do not contribute.

As clearly appeared in table 4.15, there are (61.2%) from the study participants inform others about their experience of disability, but (23%) are not ready to inform others about their disability. This means that some disabled are ashamed from the disability, while increase awareness toward this problem was demanded.

Most of key informant stated that they enhance in the positive attitude of disableds about different disability issues in the community, and this is signified by many indicators such as moving the disabled's fathers toward the society, giving the chance of the disabled to be seen by the public, and sharing in the social and institutional celebrations like international day of persons with disabilities (3 of December), while in the past the family deny or disappear the handicapped.

Again, the majority of key informants confirm the evidence change in disabled and his/ her family's attitude through different aspects of social integration such as attendance of summer camps, participation in the recreation activities, journeys and the meeting of disabled's mothers that support them, and sharing different experiences

On the other hand; PMRS and NSR directors stated that:" *social ownership was missed as the role of local community still weak". This may be changed when the people in the*

*community feel this program is to and from them, and when they services themselves with the limited resources".*

The researcher considered that public awareness with disability issues and social integration of disabled's people is currently implemented by CBR staff, but it needs more effort and follows up.

This was consistent with the study applied by Al- Yassir (2004) who evaluated CBR programs at Baqa'a Camp in Jordan and recommend to pursuing raising of public awareness vigorously.

### 4.9.3 CBR provide new practices to deal with disability:

As shown in table 4.15 there are (61.2%) of disabled became familiar with daily living activities, but (38.8%) are not familiar. There are (56.2%) can adopt better with disability by CBRPs, (41.8%) have the same dealing with disability, and (2%) their disability become worse. These results reflected the positive practical developments of CBR beneficiaries by RW's, and agree with Eide (2001) who conducted a study about the impact of CBR programs on individuals with disabilities, their families and the community in Palestine. He found substantial impact on individual functional activities, in addition to increase awareness and change negative attitude and practices.

On the other hand, most of key informants stated that, they have basic role through the home visits. Such these activities are training of the mothers about how to deal with the current disability, and teaching them the essential ADL containing physical or/and occupational exercises, speech session. Also, be sure to apply it correctly beside the psychosocial support which plants the trust between the family and RWs.

Moreover, home adaptation achieved according to the disability type, needs and according to the program's capacity.

## 4.10 Quality improvement of disabled's life

**Table 4.16: Indicators for the quality improvement of disabled life**

| Characteristics | No | % |
|---|---|---|
| **Through CBR programs, do you feel secure now?** | | |
| Yes | 133 | 66.2 |
| No | 68 | 33.8 |
| **You felt any discrimination between disabled people?** | | |
| Yes | 27 | 13.4 |
| No | 101 | 50.2 |
| Don't Know | 73 | 36.3 |
| **Suffering from disability now?** | | |
| Yes | 190 | 94.5 |
| No | 11 | 5.5 |
| **Do you still need the CBR?** | | |
| Yes | 193 | 96.0 |
| No | 8 | 4.0 |
| **To what extent the program services meet your needs?** | | |
| Some of my needs are met | 76 | 37.8 |
| Non of my needs are met | 74 | 36.8 |
| Most my needs are met | 45 | 22.4 |
| All of my needs are met | 6 | 3.0 |
| **Things that resumed by the provided services?** | | |
| Nothing | 94 | 46.8 |
| Transferee | 26 | 12.9 |
| Moving | 25 | 12.4 |
| Walking | 19 | 9.5 |
| Seeing | 9 | 4.5 |
| Going to school | 6 | 3.0 |
| Playing | 4 | 2.0 |
| Eating | 3 | 1.5 |
| Using Toilet | 2 | 1.0 |
| Hearing | 2 | 1.0 |
| Work | 1 | 0.5 |
| **Your health before CBR is?** | | |
| Good | 33 | 16.4 |
| Moderate | 45 | 22.4 |
| Bad | 123 | 61.2 |
| **Your health after CBR?** | | |
| Good | 70 | 34.8 |
| Moderate | 71 | 35.3 |
| Bad | 60 | 29.9 |
| **Your psychological health before CBR?** | | |
| Good | 26 | 12.9 |
| Moderate | 59 | 29.4 |

**Table 4.16: Indicators for quality improvement of disabled life (cont.)**

| Characteristics | No | % |
|---|---|---|
| Bad | 116 | 57.7 |
| **Your psychological health after CBR?** | | |
| Good | 61 | 30.3 |
| Moderate | 76 | 37.8 |
| Bad | 64 | 31.8 |
| **Are you satisfied about CBR programs?** | | |
| Yes | 145 | 72.1 |
| No | 56 | 27.9 |
| **Your satisfaction is?** | | |
| Good | 70 | 48.2 |
| Very Good | 47 | 32.5 |
| Moderate | 28 | 19.3 |
| Total | 145 | 100.0 |
| **By joining CBR programs, you became more independent?** | | |
| Yes | 86 | 42.8 |
| No | 115 | 57.2 |

The table above shows the quality of life domain which contains several variables that reflect the improvement of disabled people life as an outcome of the CBR programs. There are (66.2%) of the study population who feels secure after joining the CBR programs, and (50.2%) revealed the absence of discrimination through services provision, and (36.3%) don't know if there was discrimination or no, attributing this to receiving of services by RWs while they staying at their home. On the other hand, when participants were asked about their mainly demands, their answers indicated that diapers which formed (26%), and financial assistance (14%) were the most demand services. The rest distributed between broad referral, special foundation for intellectual disability, and continuous follow up.

It appears from table 4.16 that nearly (95%) of the study population are still suffering from disability as the similarly still need the CBR programs. About meeting disabled needs by CBR, there are (37.8%) some of their needs were met, while the services didn't meet (36.8%) from beneficiaries needs and (22.4%) said that most of their needs are met.

This finding is contrast with a study conducted by Marella (2010) who evaluate CBR services at Cambodian development mission for disability and found that needs of (81%) of CBR clients and (88%) of family members were met with the CBR programs.

Related to functional improvement by the CBR, there are (46.8%) with nothing resumed, followed by transfer and moving (12.9%), walking (9.5%) those related to physical disability.

The researcher suggest other factors contributed in resuming some of participant's abilities such as receiving services from other institution, and perhaps it has the large role not the CBR alone.

## Table 4.17: Distribution of feeling with discrimination by sex

| Sex | Felling discrimination | | Without felling discrimination | | Don't Know | | $X^2$ | P value |
|---|---|---|---|---|---|---|---|---|
| | No | % | No | % | No | % | 1.182 | 0.554 |
| Male | 11 | 10.9 | 53 | 52.5 | 37 | 36.6 | | |
| Female | 16 | 16 | 48 | 48 | 36 | 36 | | |

Table 4.17 shows that, females (16%) feel with discrimination more than males (10.9%), and the rest don't know if there was discrimination or not justified that to their contact with the programs staff which was only during the home visits. By using Chi-square test, the variation related to feelings discrimination was not reach statistical significant ($X^2$ 1.182, P-value 0.554,). This indicates an absence of bias through provision of CBR services among male and female. The results agree with the convention of disabled rights that always called for equal opportunities for persons with disability without vulnerability or discrimination.

## Table 4.18: Differences in services scores and meeting disabled needs

| Meeting needs groups | Mean | SD | F | P-value |
|---|---|---|---|---|
| All of my needs are met | 2.00 | 0.632 | 25.16 | 0.001* |
| Most my needs are met | 2.311 | 1.040 | | |
| Some of my needs are met | 1.907 | 1.035 | | |
| None of my needs are met | 0.8919 | 0.803 | | |

Table 4.18 explains that; differences among the first 3 means were little, meaning that services means related to the first 3 categories was nearly equal, but the difference was observed in the category "none of my needs are met" which reach statistically significant (P value 0.001).

Post Hoc test (Scheffe) indicated the difference between groups presented in the category none of needs are met, meaning that the response of disabled needs influenced by the provided services. Thus, more services will meet most of disabled needs. Although disabled people in category 4 received services, nothing of their needs was met. This is may be due to many factors. The most proposed one is limitation of services mainly disability differs from one to another in its type and severity, while they require constant and essential needs. The quality of services may be poor, or disabled persons miss understanding the RW's task as a facilitator or trainer not health care provider, so they had high expectation of benefits. In reality, interpretation of this issue needs to be considered and studied in depth.

## Table 4.19: Differences in disabled physical and psychological status by CBR

| Physical Status | | After CBR (%) | | | Total | $X^2$ | P value |
|---|---|---|---|---|---|---|---|
| | | Good | Moderate | Bad | | | |
| Before CBR (%) | Good | 15.9 | 0 | .5 | 16.4 | 91.0 | 0.001 |
| | Moderate | 8.0 | 12.9 | 1.5 | 22.4 | | |
| | Bad | 10.9 | 22.4 | 27.9 | 61.2 | | |
| | Total | 34.8 | 35.3 | 29.9 | 100. | | |
| **Psychological Status** | | **After CBR (%)** | | | **Total** | **$X^2$** | **P value** |
| | | **Good** | **Moderate** | **Bad** | | | |
| Before CBR (%) | Good | 10.9 | 2.0 | .0 | 12.9 | 73.6 | 0.001 |
| | Moderate | 12.9 | 12.9 | 3.5 | 29.4 | | |
| | Bad | 6.5 | 22.9 | 28.4 | 57.7 | | |
| | Total | 30.3 | 37.8 | 31.8 | 100 | | |

Table 4.19 demonstrates the change in disabled's health including physical and psychological status by CBR. First the physical status as the disabled with good status increased by 18.4%, while those with moderate increased from 22.4% to 35.3% and those with bad condition improved where they declined from 61.2 to 29.9%. Second the

change in the psychological status of disabled there it was raised of good status from 12.9% to 30.3%, at the same time, those with moderate status increased from 29.4% to reach 37.8%, and the bad cases improved by 25.9%. Generally, it was necessary to state that some cases were improved 41%, and some stay at the same condition 53.5%, while 5.5% are deteriorated.

It was achievement of the CBR programs for some disabled who remaining at the same condition, because without CBR services disabled will suffer complication and deterioration. WHO (2010) stated that CBR does not only produce supportive services to promote disabled and their families health, but also prevent the development of secondary problems since they are at risk of complications which are related to their primary health state like pressure sores, urinary tract infections, joint contracture, pain, osteoporosis, depression and others. On the other hand, worsen of some cases resulted from the severity and the nature of disability like muscular dystrophy disease that sometimes leads the case to be hopeless.

To see the correlations between the CBR and the change in both physical and psychological condition, Pearson correlation indicates that it was positive, but weak correlation between services and the improvement in the physical status (Pearson correlation 0.188, P value 0.008). Another correlation test was done between services and psychological state (Pearson correlation 0.152, P value 0.031). At the same time, positive and good correlation was found between physical and psychological change as shown in annex (16). The last results are logic as the improvement of physical condition of the disabled reflects on his psychological state and vice versa.

**Table 4.20: Distribution of disabled's satisfaction by sex**

| Sex | Satisfied | | Not Satisfied | | Total | | $X^2$ | P value |
|---|---|---|---|---|---|---|---|---|
| | No | % | No | % | No | % | 0.453 | 0.501 |
| Male | 75 | 74.3 | 26 | 25.7 | 101 | 100 | | |
| Female | 70 | 70 | 30 | 30 | 100 | 100 | | |

As shown in table 4.20, male are satisfied more than female. Despite this difference, and by using of chi-square the difference was not reach statistically significant ($X^2$ 0.453, P-

value 0.501). The researcher attributed this to the absence of the discrimination among gender through CBR programs, and to the disabled's contentment.

### Table 4.21: Differences in quality of life domains to CBR services scores

| Services Scores | N | Mean | SD | F | Sig |
|---|---|---|---|---|---|
| 0 | 26 | 1.653 | 1.41258 | 7.062 | 0.001 |
| 1 | 78 | 2.859 | 1.51807 | | |
| 2 | 56 | 3.142 | 1.61165 | | |
| 3 | 30 | 3.866 | 1.00801 | | |
| 4 | 9 | 4.333 | 1.32288 | | |

As the literature reviewed; quality of life for disabled's people demonstrated through indicators extracted from QOL domains. The researcher expressed QOL domains through the next items. Those are: feeling security, change in health status (physical and psychological) which reflects the programs effectiveness, social participation, and the satisfaction.

In table 4.21, high mean scores were elicited among participants who have more services than others with statistically significant differences (P value 0.001). Correlations show, there was a positive and middle relation between QOL domains and services scores (Pearson correlation 0.376 P value 0.001). These findings signify that increasing the provided services enhances the quality of life for people with disability, and finally this result was the intended part of CBR programs.

## 4.11 Beneficiaries opinion for developing the CBR programs

With regards to beneficiaries opinions about subjects that pleasant those from the CBR programs, table 4.22 illustrated that program's staff interaction was the common one (37.3%), while services forms (21%) where (18%) of the rest pleasant by commitment and (24%) by nothing. At the same time, nearly (50%) of the study population suffers from poor services, and (38.3%) have no complaint, where the rest experience difficulty to access the rehabilitation place and lack of professionals (2.5%).

For CBR developing, most of beneficiaries (71.6%) are recommended to increase services, (53.7%) suggested gaining disabled's rights, while (27.3%) suggested collaboration with other sectors.

**Table (4.22): Perspectives of beneficiaries about developing the CBR**

| Characteristics | No | % |
|---|---|---|
| **Things pleasant you from CBR** | | |
| Staff Integration | 75 | 37.3 |
| Nothing | 48 | 23.9 |
| Present Services | 42 | 20.9 |
| Commitment | 36 | 17.9 |
| **Fury you from CBR** | | |
| Poor Services | 90 | 44.8 |
| Nothing | 77 | 38.3 |
| less Commitment | 21 | 10.4 |
| Difficult to access the place | 5 | 2.5 |
| Lake of Professionals | 4 | 2.0 |
| Staff Interaction | 2 | 1.0 |
| Others | 2 | 1.0 |
| **For CBR development** | | |
| Increase Services | 144 | 71.6 |
| Increase Staff | 17 | 8.4 |
| more Communication | 10 | 5.0 |
| Collaboration with other sectors | 55 | 27.3 |
| Right Advocacy | 108 | 53.7 |
| More Equipment | 5 | 2.4 |
| Other the current services | 8 | 3.9 |

Related to beneficiarie's comments, there are (5%) of them asked to increase the rehabilitation staff mainly physiotherapist, and the rest need more equipment, communication, and more services such as cash assistance.

The above results in table 4.22 translated the good relation ship between RWs and People with disabilities which emerge from good interaction especially through home visits. On the other hand, it indicates disabled's requests for provision of more services to face the daily recurrent and necessary needs.

As a result of beneficiaries' opinion about poor services, the researcher shows that CBR programs lacked the community participation which is vital and essential principle of the CBR through sharing and introducing the different available services for disabled persons. At the same time, the study participants conceptualized the CBR programs as

services provider for their essential needs. So this point needs to be clarified and explained.

## 4.12 The CBR programs strengths and weaknesses

Related to the strength points of CBRPs, the majority of the key people have the same opinion that CBR programs provides extended and specific services for people with disabilities particularly inclusive education and health services, and especially at times of crises. Also, the communication with the disabled's family, professional team with great experience, and the work's transparency considered as a strength points of CBRPs.

The director of PMRS said: *"delegations from the high level management, the depth of the programs, disabled satisfaction, and professional team are the main strength points".* While the NSR director said: *"the continues support from the donor without obligation of work agenda, the direct relation between executive and politic body of the society, having of the place that has large gathering space, having data base, computer lab and having a shop for repairing the assistive device are strength points".*

About CBRPs weaknesses; all key informants have consensus that stopping the donation of the programs is the first risk that threaten their work, considering this the most negative point in the CBRPs.

At the same time, some key informants think that there is a shortage in RW's number, and this leads to increase the workload of staff and affect the work quality.

One of RWs stated that, decrease the quantity of RWs with the workload causing us to "*nshalfeg el shogkel*" this mean do the work speedy and in a hurry way.

On this point and based on the concept of CBR in which referral and networking are main principles, the researcher perceived that although the overwhelming duties of CBRPs, a proper management of the available resources include the human resources could compensate the limited number in RWs and overcome this obstacle through empowering of referral services and good coordination with other sectors.

At the same time, some of key informants stated that the limited resources, the current political situation, and the lacks of computerized work which add more efforts and time to RWs are constitute other obstacles of the CBR programs.

# Chapter (5)
# Conclusion and Recommendations

## 5.1 Main Conclusion

In an attempt to evaluate the community based rehabilitation (CBR) programs in Gaza and the North governorates, the current study was conducted at two main CBR providers; PMRS and NSR. The study included three methods namely: a self conducted questionnaire for 201 beneficiaries, key informants' interview, and reviews of 20 medical files.

The results of the study illustrated that the majority of disability (71.6%) caused by acquired causes, mainly by accidents which constituted (52.1%) including birth accident, falling down, CVA, and road traffic accident. Among the disability types; physical disability was the common one which forms (76.1%). Also, it was found that the focus of CBRPs was more toward children than adults.

The results of the study showed that program's activities have several services such as health, social, and educational one. The prominent one was relief aids (42.8%), followed by assistive devices and physiotherapy, while vocational training and employment that forms (0.5%) are the poorest at the moment access to training and work opportunities for disabled are needed.

Regarding the frequency of visits (50.3%) of CBR beneficiaries received services by less than one visit per month. At the same time, there was no statistically significant variation between the provided services for both male and female, and there was no statistically significant difference of feeling with discrimination among both sexes.

The study illustrated the program's effectivity through its respond to the disabled's needs, improvement in the disabled's physical and psychological state, while there was positive directly proportional relation between improvement in the quality of life and the provided services, (pearson correlation 0.376 P value 0.001).

Concerning the multisectoral collaboration, the study results revealed that there is networking with other sectors mainly local NGOs, but also there is a weak coordination with governmental and international sectors except at educational part.

The programs increased the disabled people's knowledge about disability issues, but on the other hand there are many issues that people with disabilities are not familiar with, and need to be aware of. Such issues are recognition of the CBR programs, disabled people's responsibilities, and their rights.

Again, the study revealed that CBRPs worked on improving disabled's attitude in regard to disability, this was signified by many indicators such as contribution of the disabled's fathers in the rehabilitation process, and sharing the disabled in social and institutional celebrations. But changing the concepts about disability issues in the public still needs more efforts and work. This was elicited through the lack of the community mobilization toward the program's activities.

At the same time, the study demonstrated that about (61.2%) of disableds become skillful in their daily living activities since they acquired new skills that emphasis their ability to face different difficulties. Furthermore, there were (66.2%) from disabled persons who feel secure, (53%) resumed different abilities by CBRPs.
There was good change in the physical and psychological state of disabled, while the disabled's person has the same chance in improving his/her quality of life through CBRPs. We can say CBRPs are effective, but it needs more care and support from different sectors.

The study indicated that CBRP didn't concentrate on empowering domain and the disabled's rights. At the same time, the application of disability law was inactive, and it needs intensive and real collaboration from different partners including CBRPs itself, Palestinian authority, people with disabilities, national and international NGOs and others. The study shows that the huge demand of CBRPs related to the limited RW's staff, and the absence of volunteers affected its quality.

The study revealed that the filing system does not include complete information related to disableds. There is a lack of setting the rehabilitation plan, which must contain specific indicators for each disabled depending on the type and severity of the disability. Another lack that the researcher witnessed was in the disabled follow up and the evaluation process which is necessary to evaluate the programs outcome.

## 5.2 Recommendations

### 1. Establishment of a National Strategy

National strategy based on a real multi-sectoral approach aiming to create awareness about the disability issues such as poverty reduction programs, prevention mainly acquired disability, and attitudinal change for public or disabled people. Applying this strategy will lead to integrated work and avoid duplications.

### 2. Developing of a local committee

Such committee should be initiated inorder to establish policies for CBRPs, and considered as an umbrella for its different activities that help in the implementation of CBRPs mainly in the difficult situations.

### 3. Support the sustainability of CBR activities

- Strengthening the voluntary work and the social ownership in the CBRPs, the things that increase the community's participation.
- Empowering the disableds role in the community to advocate their rights.
- Constructing an income generating projects or resources to decrease the external fund dependency & increase the disabled's employment chance.
- Supporting the current activities mainly the coordination between the main rehabilitation providers, and focusing on livelihood and empowering activities.
- Developing the staff capacity inorder to increase their performance, thus improve the quality.
- Enhancing the role of other sectors such as primary health care, UN agencies, and ministries through working groups.
- Planning for better use of services and reallocation of the available limited resources.

### 5.2.1 Recommendations for further studies

- A study of disabled's status to find the impact of CBR programs pre and post joining it in different areas like health status, education and others.
- A study to examine the cost-effectiveness of CBRPs, and the efficiency of the programs on the Palestinian health care system.

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## Annex (1): Map of Gaza Governorates

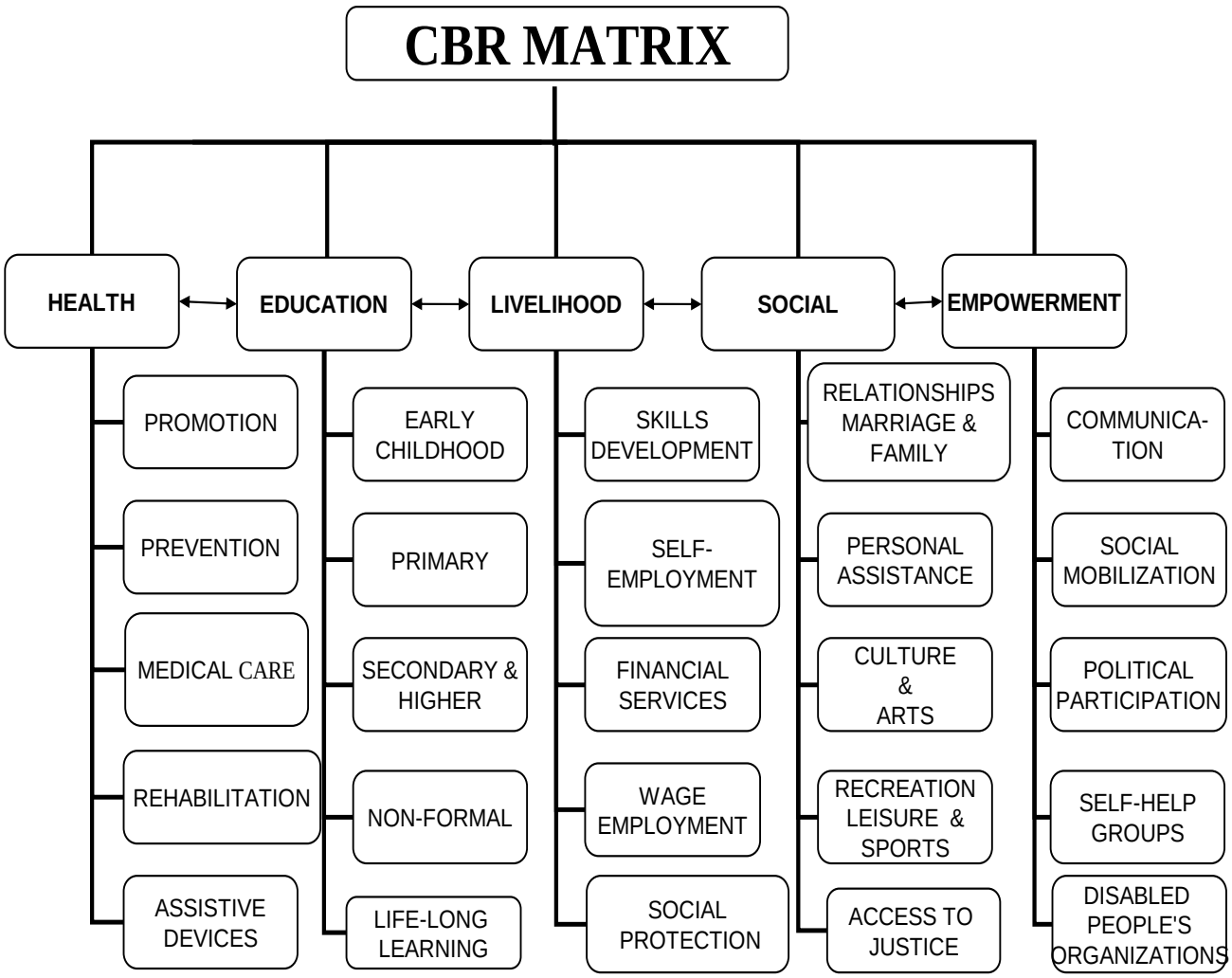

**(Ministry of Planning, 2006)**

## Annex (2): Disability types

**Table for the Percentage of Individual with Special Needs by selected variables in Gaza and West bank (PCBS, 2007).**

| | Seeing | Hearing | Communication | Physical | Self-care | Dealing with others |
|---|---|---|---|---|---|---|
| **Palestinian Territory** | 0.76 | 0.43 | 0.60 | 1.29 | 0.30 | 0.26 |
| West bank | 0.95 | 0.51 | 0.61 | 1.36 | 0.33 | 0.25 |
| Gaza Strip | 0.48 | 0.30 | 0.59 | 1.18 | 0.25 | 0.28 |
| **Sex** | | | | | | |
| Male | 0.77 | 0.48 | 0.71 | 1.48 | 0.30 | 0.31 |
| Female | 0.75 | 0.38 | 0.49 | 1.09 | 0.29 | 0.21 |
| **Locality Type** | | | | | | |
| Urban | 0.70 | 0.39 | 0.50 | 1.24 | 0.28 | 0.24 |
| Rural | 0.84 | 0.50 | 0.74 | 1.18 | 0.31 | 0.30 |
| Camp | 0.83 | 0.42 | 0.67 | 1.62 | 0.31 | 0.28 |

**Annex (3): CBR Matrix**




**Source: (WHO et al., 2007)**

## Annex (4) :Disabled's Number in Gaza Strip

### اولا: إحصائيات إجمالية عن قطاع غزة

جدول رقم-1-

- عدد المعوقين في قطاع غزة حسب المنطقة والفئة العمرية والجنس

| المنطقة | 15=> | | | | | | 15< | | | | المجموع | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | ذكور | % | إناث | % | المجموع | % | ذكور | % | إناث | % | المجموع | % |
| الشمال | 926 | 2.7% | 731 | 2.1% | 1,657 | 4.8% | 1,733 | 5.0% | 1,284 | 3.7% | 3,017 | 8.7% | 4,674 | 13.5% |
| غزة | 1,272 | 3.7% | 1,053 | 3.0% | 2,325 | 6.7% | 4,096 | 11.9% | 3,239 | 9.4% | 7,335 | 21.2% | 9,660 | 28.0% |
| الوسطى | 1,025 | 3.0% | 957 | 2.8% | 1,982 | 5.7% | 3,173 | 9.2% | 2,924 | 8.5% | 6,097 | 17.6% | 8,079 | 23.4% |
| خانيونس | 1,134 | 3.3% | 975 | 2.8% | 2,109 | 6.1% | 3,630 | 10.5% | 2,883 | 8.3% | 6,513 | 18.8% | 8,622 | 25.0% |
| رفح | 436 | 1.3% | 404 | 1.2% | 840 | 2.4% | 1,391 | 4.0% | 1,286 | 3.7% | 2,677 | 7.7% | 3,517 | 10.2% |
| المجموع | 4,793 | 13.9% | 4,120 | 11.9% | 8,913 | 25.8% | 14,023 | 40.6% | 11,616 | 33.6% | 25,639 | 74.2% | 34,552 | 100.0% |

## Annex (5): Helsinki committee approval

17

**Palestinian National Authority**
**Ministry of Health**
**Helsinki Committee**

**السلطة الوطنية الفلسطينية**
**وزارة الصحة**
**لجنة هلسنكي**

التاريخ7/6/2010

Name:

**الاسم: سعاد جميل رضوان**

I would like to inform you that the committee has discussed your application about:

نفيدكم علماً بأن اللجنة قد ناقشت مقترح دراستكم حول:-

**Evaluation of community based Rehabilitation programs in the North and Gaza Governorates.**

In its meeting on June 2010

and decided the Following:-

To approve the above mention research study.

و ذلك في جلستها المنعقدة لشهر 6 2010

و قد قررت ما يلي:-

الموافقة على البحث المذكور عاليه.

Signature
توقيع

Member
عضو

Member
عضو

Chairperson

Conditions:-

- Valid for 2 years from the date of approval to start.
- It is necessary to notify the committee in any change in the admitted study protocol.
- The committee appreciate receiving one copy of your final research when it is completed.

## Annex (6): Agreement letter from NSR director


Al-Quds University
Jerusalem
School of Public Health

جامعة القدس
القدس
كلية الصحة العامة


2010/7/21

الأخ/ كمال أبو قمر المحترم
المدير التنفيذي للجمعية الوطنية لتأهيل المعوقين
تحية طيبة وبعد،،،

الموضوع: مساعدة الطالبة سعاد رضوان

تقوم الطالبة المذكورة أعلاه بإجراء بحث بعنوان:

***" Evaluation of community based rehabilitation programsin the north and gaza governorates"***

كمتطلب للحصول على درجة الماجستير في الصحة العامة- مسار ادارة صحية و عليه نرجو التكرم للإيعاز لمن ترونه مناسب لتسهيل مهمة الطالبة في جمع البيانات اللازمة من جمعيتكم الموقرة .
علماً بأن المعلومات ستكون متوفرة لدى الباحث و الجامعة فقط.

و اقبلوا فائق التحية و الاحترام،،،

د. بسام أبو حمد
منسق عام برامج الصحة العامة

نسخة:
- الملف


Jerusalem Branch/Telefax 02-24799234
Gaza Branch/telefax 08-2884422-2884411
Sphealth@admin.alquds.edu
فرع القدس/تلفاكس 02-2799234
فرع غزة/تلفاكس 08-2884422-2884411
ص.ب/51000-القدس

## Annex (7): Agreement letter from PMRS, Gaza


Al-Quds University
Jerusalem
School of Public Health

جامعة القدس
القدس
كلية الصحة العامة


2010/7/21

الأخ/ د. عائد ياغي المحترم
مدير جمعية الاغاثة الطبية
تحية طيبة وبعد،،،

الموضوع: مساعدة الطالبة سعاد رضوان

تقوم الطالبة المذكورة أعلاه بإجراء بحث بعنوان:

***" Evaluation of community based rehabilitation programsin the north and gaza governorates"***

كمتطلب للحصول على درجة الماجستير في الصحة العامة– مسار ادارة صحية و عليه نرجو التكرم للإيعاز لمن ترونه مناسب لتسهيل مهمة الطالبة في جمع البيانات اللازمة من جمعيتكم الموقرة .
علماً بأن المعلومات ستكون متوفرة لدى الباحث و الجامعة فقط.

و اقبلوا فائق التحية و الاحترام،،،

د. بسام أبو حمد
منسق عام برامج الصحة العامة

نسخة:
- الملف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ص.ب/51000-القدس

**Annex (8): Informed consent for CBR beneficiaries**

## استبيان

## تقييم برامج التأهيل المبنى على المجتمع في كل من محافظتي الشمال وغزة

**عزيزي/تى المشارك:**

أنا الباحثة سعاد جميل رضوان، طالبة في برنامج الماجستير في كلية الصحة العامة جامعة القدس- فلسطين.

أقوم بهذا البحث كجزء من دراستي في الجامعة , حيث تهدف هذه الدراسة إلى تقييم برامج التأهيل المبنى على المجتمع والذي يقدم لذوى الاحتياجات الخاصة في محافظات غزة والشمال لكي نلقى الضوء على نشاطات هذه البرامج وتقييم الخدمات التي يقدمها , ومن ثم ض ع مقترحات من الممكن أن تساهم في تحسين العمل لخدمة هذه الشريحة من المجتمع الفلسطيني.

لا يوجد إجابات خاطئة أو صائبة، لذا نرجو الإجابة على الأسئلة بمصداقي ة قدر الإمكان ،إجابتك ستكون سرية وستجمع مع الإجابات الأخرى، لذلك أرجو إجابة جميع الأسئلة.

الاستبيان يستغرق اقل من 20 دقيقة مع العلم أن مشاركتك طوعية و لك الحق في الانسحاب وقتما تشاء موقنين أن مشاركتك ستعزز من البحث العلمي.

شكرا لمشاركتك

الباحثة

سعاد رضوان

**Annex (9): Informed consent for key informant**

## تقييم برامج التأهيل المبنى على المجتمع في كل من محافظتي الشمال وغزة

**عزيزي/تى المشارك:**

أنا الباحثة سعاد جميل رضوان، طالبة في برنامج الماجستير في كلية الصحة العامة جامعة القدس- فلسطين.

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مشاركتك ستكون من خلال مقابلة، هذا وقد تستغرق المقابلة من 20-30 دقيقة وان المعلومات ستحفظ بسرية تامة والهدف منها البحث العلمي لا غير.

لك الحق في القبول أو الرفض علما أن مشاركتك ستعزز من البحث العلمي.

شكرا لتعاونك في إجراء المقابلة

الباحثة

سعاد رضوان

## Annex (10): Beneficiaries' questionnaire

| | | | | |
|---|---|---|---|---|
| 1. Serial number…… | 2. Governorate……. | | Telephone…… | |
| **Personal Characteristics** | | | | |
| 3. Gender | ☐ Male | ☐ Female | 4. Age ……year | |
| 5. Social status before the disability | ☐ Single | ☐ Married | ☐ Divorced | ☐ Widow |
| 6. Social status after the disability | ☐ Single | ☐ Married | ☐ Divorced | ☐ Widow |
| 7. Previous occupation…… | | 8. Current Occupation …… | | |
| 9.Level of education | …….. | | | |
| 1o. Family monthly income New Israeli Shakel (NIS) | ……. | | | |
| 11. Disability type? | ☐ Physical ☐ Visual ☐ Hearing<br>☐ Speech ☐Strange behavior ☐ Other-------- | | | |
| 12. Cause of disability | ☐ Congenital ☐ Acquired | | | |
| 13. If acquired, the reason was? | ☐ War ☐ Accident ☐ Communicable disease<br>☐Non Communicable disease ☐ Others---------- | | | |
| **Services** | | | | |
| 14. Types of services that received? | ☐ Physiotherapy ☐ Occupational therapy ☐Assistive devices<br>☐ Medical services ☐ Speech therapy ☐ Health education<br>☐Referral ☐ Vocational training ☐ Employment<br>☐ Integration ☐ Relief services ☐ Adaptation<br>☐ Social and psychological support ☐ Others---------- | | | |

| | |
|---|---|
| 15. You know about the CBR activities from? | ☐ Friends ☐ CBR staff ☐ Disabled people<br>☐ Neighbors ☐ Others---------- |
| 16. You received CBR services through home visits for you? | ☐ Yes ☐ No |
| 17. Did you receive CBR services through a team? | ☐ Yes ☐ sometimes ☐ No |
| 18.The number of visits per month-------- | Average time of visit---------- minute |
| 19. Do you receive the services from other rehabilitation institutions? | ☐ Yes ☐ No |
| 20. If yes, why you are seeking services from other institutions? | ☐ Sufficient professionals ☐ More services<br>☐ Less expensive ☐ better quality<br>☐ without any justify ☐ Others---------- |
| **Multi-sectoral Collaboration** | |
| 21. Providers of CBR services refer you to other institutions? | ☐ Yes ☐ No |
| 22. What were these institutions? | ☐ International ☐ NGOs<br>☐ Governmental ☐ Private |
| 23. Do you feel true collaboration from these organizations? | ☐ Yes ☐ sometimes ☐ No |
| **Institutional Characteristics** | |
| 24. Do you visit the rehabilitation society? | ☐ Yes ☐ No |
| 25. What are the reasons for your visits? | ---------- |
| 26. Do you find difficulties to access the rehabilitation society? | ☐ Yes ☐ sometimes ☐ No |
| 27. If yes, the source of this difficulty was? | ☐ Unclear address ☐ Transportation<br>☐ Financial issues ☐ long waiting time ☐others--- |

| | |
|---|---|
| 28. Is there any environmental adaptation in the rehabilitation society to ensure ease of access as ram for wheelchair? | ☐ Yes ☐yes, To some extent ☐ No |
| 29. Does the rehabilitation society provide recreation activities? | ☐ Yes ☐ No |
| **Responsibility of Rehabilitation workers (RWs)** | |
| 30. Have you received explanation about your condition from RWs even you don't ask? | ☐ Yes ☐ No |
| 31. If you have a question, did the rehabilitation workers listen to your inquiries? | ☐ Yes ☐ No |
| 32. They answer your questions completely? | ☐ Yes ☐ No |
| 33. Have the RWs promise to visit you, but they ignore it? | ☐ Yes ☐ No |
| 34. If yes, what the frequency of this action? | ---------- |
| 35. Do you feel that rehabilitation workers spend enough time with you? | ☐ Yes ☐ No |
| 36. Have you informed by RWs about your rehabilitation plan such as the type of therapist, length of time? | ☐ Yes ☐ No |
| 37. Did the RWs offer feedback for you such as assessment, rehabilitation results? | ☐ Yes ☐ No |
| 38. Do feel that RWs respect you as a human being during providing the services? | ☐ Yes ☐ No |
| 39. Rehabilitation workers guide you on ways to prevent future problems? | ☐ Yes ☐ No |
| 40. Your expression about the rehabilitation staff skills is? | ☐Good ☐ Moderate ☐ Bad ☐ Don't Know |
| **Management of Community Based Programs** | |
| 41. Have you been involved in setting of your rehabilitation plan? | ☐ Yes ☐ No |

| | |
|---|---|
| 42. Your management implemented through documented plan? | ☐ Yes ☐ No |
| 43. Is there follow up of your case? | ☐ Yes ☐ No |
| 44. Are you involved in the evaluation of your rehabilitation plan? | ☐ Yes ☐ sometimes ☐ No |
| 45. If yes, what was the frequency of evaluation? | ☐ Every 3month ☐ Every 6 month ☐ Annual ☐ Don't know |
| 46. Have you pay a fee for the society? | ☐ Yes, full fee ☐ Yes, partial fee ☐ No |
| 47. If yes, how many? …… | |
| **Enhance Knowledge , Attitude and Practice (KAP)** | |
| 48. You know what is this program? | ☐ Yes ☐ No |
| 49. You know about disabled people law? | ☐ Yes ☐ No |
| 50. Do you recognize the complications that might affect you at the future? | ☐ Yes ☐ No |
| 51. Currently, do you know how to prevent such these complications? | ☐ Yes ☐ No |
| 52. After you're joining the CBR programs, you deal better with daily problems? | ☐ Yes ☐ No |
| 53. Are you integrated in your family now? | ☐ Yes ☐ To some extent ☐ No |
| 54. At present, do you participate in social events in your community? | ☐ Yes ☐ To some extent ☐ No |
| 55. Currently do you participate in celebrations that hold in the society? | ☐ Yes ☐ To some extent ☐ No |
| 56. How you describe your current interaction with others (friends, relatives)? | ☐ Good ☐ Moderate ☐ Bad |
| 57. Do you learn other disabled people about your journey with disability to be useful? | ☐ Yes ☐ Sometimes ☐ No |
| 58. You can adopt with disability now? | ☐ Better ☐ The same ☐ Worse |

| **Enhance Quality of disabled life** | | |
|---|---|---|
| 59. Do you feel secure now? | ☐ Yes ☐ No | |
| 60. Have you felt that the CBR staff discriminates between disables people? | ☐ Yes ☐ Don't Know ☐ No | |
| 61. If yes, mention the type of discrimination? | ---------- | |
| 62. Are you suffering from disability now? | ☐ Yes ☐ No | |
| 63. Do you still need the CBR programs? | ☐ Yes ☐ No | |
| 64. To what extent did the services you received meet your needs? | ☐all of my needs are met<br>☐ most of my needs are met<br>☐some of my needs are met<br>☐non of my needs are met | |
| 65. What services did you want but didn't receive? | ---------- | |
| 66. Things that resumed by the CBR programs? | ☐ Eating ☐Using toilet ☐ Moving<br>☐ Hearing ☐ Going to school ☐ Playing<br>☐ Work ☐Transfer ☐Nothing ☐ Others---- | |
| 67. How you describe your health status before CBR programs? | Physical<br>psychological | ☐Good ☐Moderate ☐Bad<br>☐Good ☐Moderate ☐Bad |
| 68. How you describe your current health status in comparison to the time of joining the programs? | Physical<br>psychological | ☐Good ☐Moderate ☐Bad<br>☐Good ☐Moderate ☐Bad |
| 69. Are you satisfied about the CBR programs? | ☐ Yes ☐ No | |
| 70. How you describe your overall satisfaction about CBR programs? | ☐Very good ☐ Good ☐ Moderate | |
| 71. Through the CBR programs you have become more independent? | ☐ Yes ☐ No | |

| | |
|---|---|
| 72. What thing that pleasant you from the CBR programs? | ☐ Staff interaction ☐ Communication<br>☐ Services ☐ Nothing ☐ Other |
| 73. What thing that fury you from the CBR programs? | ☐ Poor services ☐ Staff Interaction<br>☐ Fees ☐ Less Commitment<br>☐Difficult to access the society ☐ Other---------- |
| 74. From your opinion how can the CBR programs are developed?<br>(Circle all correct answers) | ☐ Increase services ☐ Increase staff<br>☐ Improve communication ☐ Rights advocacy<br>☐Collaboration with other sectors<br>☐ More equipment ☐Other---------- |
| 75. Any additional comment ……<br>……<br>…… | |

## Annex (11) interview questions for society directors

**1. Please, can you describe the main activities that hold in your programs?**

**[Probe**: *Health, Education, Social, Empowerment and Livelihood*?**]**

**2. For whom of disabled people the local priorities are set?**

[**Probe:** *Children, elders, Youth or women? How that relevant to the Palestinian culture*?**].**

**3. Please, explain about disability law application?**

**{Probe**: *advocacy, pressure committee, disabled's participation***?}**

**4. As a director of CBR program; Please tell me how can you empower the disabled person & his/her family in program's decisions?**

**[Probe**: *Involvement? Participation*? Sharing?**]**

**5. How dose the capacity of the CBR management promote specific rights of partners and DPOs towards the duty of authorities)?**

**[Probe**: *National/ International Committee? Collaboration with other sectors***?]**

**6. Which efforts take place to maintain the program sustainability within difficult political situations?**

**[Probe:** *Collect economic resource s& Support by government*? Community participation? **]**

**7. With the knowledge and experience you have today; what would you have done differently?**

- Program design; include advocacy and pressure committee or developing of Policy?
- Partnership – selection of partners, criteria?
- Follow-up, capacity-building, training of partners?

**8. What are the monitoring & evaluation systems that the program deals? [Probe:** *What information systems and databases are in use*?**].**

**9. From your opinion, what are the main strengths & weak points? your recommendations to maintain more helpful CBR programs?**

## Annex (12): Interviews questions for CBR Supervisor and Providers

1. **Please, describe the main activities that are hold in your programs?**
   **[Probe:** *Health, Education, Social, Empowerment and Livelihood.***]**
2. **How does CBR achieve the different needs of disabled/families?**
   **[Probe**: *Networking? Community Participation? Collaboration with others*?]
3. **Which rights are the CBR programs focuses, what about disability law?**
   **[Probe:** *Education, Health? Empowerment or Livelihood, Social "sports, personal assistance"? What about marriage, political participation and employment*?]
4. **How can the rehabilitation worker gain the right of education for disabled?**
   **[Probe:** *Early childhood development, integration within public schools, primary? Secondary, higher education?***]**
5. **How can you ensure that the applied work run in the right way?**
   **[ Probe:** *Follow up, Evaluation? Any documentation of monitoring visits? Success stories?***]**
6. **please, tell me about steps that taken to promote programs sustainability in your organization?**
   **[Probe:** *Disables communication, Self reliance and Wage employment*? *Responsibility for rehabilitation by the community*?**]**
7. **Now, do you feel alteration in the acceptance of disabled/family for the program?**
   **[Probe:** *Accept the programs? Change in attitude? Increase Knowledge? Dealing better practically with disability? Participation in social activities*?**]**
8. **How are the local needs & priorities determined?**
   [**Probe:** *Assessment, Special criteria? Involved of disabled / families? Sharing of? Any regular meeting or consultation with the management? Reporting?***]**

9. **From your opinion what are the main strengths & weak of CBR programs?** The main gaps? Recommendations to maintain more effective results?

**Annex (13): Checklist of medical records** (Select 10 records at random)

**Institution: ……** **Date: ……..**

| **Checklist items** | **Complete Filling** | **Partial Filling** | **Not Filling** |
|---|---|---|---|
| Identification of patient | | | |
| Demographic data: - Age | | | |
| -Address | | | |
| -Telephone | | | |
| Date of service is recorded | | | |
| Disability type | | | |
| Imaging report, laboratory | | | |
| Client assessment | | | |
| Setting of plan | | | |
| Involvement of family | | | |
| Follow up-plan | | | |
| Documentation of follow up | | | |
| Evaluation | | | |
| Staff signatures | | | |

**Comment:**

## Annex (14): Request for evaluation and controlling questionnaire

## استمارة تحكيم

**السيد/_____حفظه الله**

السلام عليكم ورحمة الله وبركاته""

تقوم الباحثة سعاد جميل رضوان بإجراء دراسة بعنوان:

**Evaluation of the Community Based Rehabilitation Programs in the North and Gaza Governorates**

وذلك استكمالا لمتطلبات الحصول على درجة الماجستير في الصحة العامة – مسار إدارة صحية.

نظرا لثقة الباحثة بكم فإننا نضع بين أيديكم أداة الدراسة الموجهة بتقييم برامج التأهيل المبنى على المجتمع في كل من محافظتي الشمال وغزة.

لذا أرجو منكم إبداء الرأي للوقوف على صحة وصدق الاستبانة, وكذلك مدى ملاءمتها لأهداف الدراسة, إذ أن ملاحظاتكم وآراءكم ستثري هذه الأداة لتصبح أكثر منهجية وتحقق الأهداف المرجوة منها.

ملاحظة: مرفق أهداف الدراسة, أسئلة البحث وكذلك الاستبانة المراد تحكيمها.

شاكرين لكم مساهمتكم لائراء هذه الدراسة ودعمكم للبحث العلمي.

الباحثة
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## Annex (15): Names of experts

| | | |
|---|---|---|
| 1 | Dr. Bassam Abu Hamad | Al-Quds University |
| 2 | Dr. Yousof El Jeash | Islamic University |
| 3 | Dr. Kamees El Essy | EL waffa Hospital |
| 4 | Mr. Sadi Abu Awwad | Al-Quds University |
| 5 | Mr. Mahmoud El Dama | Former director planning Department-MOH |
| 6 | Mr. Hussean Abu Manssor | Jabalia Rehabilitation Society |
| 7 | Mr. Nasser Ghanem | University College of Applied Sciences |
| 8 | Mr. Mustafa Abed | Palestinian Medical Relief Society |
| 9 | Mr. Kamal Abu Kamour | National Rehabilitation Society |
| 10 | Mrs. Alia El Geshawy | MOH, Rehabilitation Unit |
| 11 | Mrs. Jehan Hillis | MOH, Human Resource Department |

**Annex (16): Correlations between change of physical and psychological states and service scores**

| Variable | | Improve physical | Improve psychological state | service scores |
|---|---|---|---|---|
| Improve physical health | Pearson Correlation | 1 | .410** | .188** |
| | Sig. (2-tailed) | | .000 | .008 |
| | N | 201 | 201 | 201 |
| Improve psychological state | Pearson Correlation | .410** | 1 | .152* |
| | Sig. (2-tailed) | .000 | | .031 |
| | N | 201 | 201 | 201 |

*Correlation is significant at the 0.05 level (2-tailed).

# Arabic Abstract

## تقييم برامج التأهيل المبنى على المجتمع في كل من محافظتي الشمال وغزة

**إعداد: سعاد جميل رضوان**

**إشراف: د. يحيى عابد**

**ملخص الدراسة:**

التأهيل المبنى على المجتمع هو مجال هام وخاص لذوي الاحتياجات الخاصة. هذه الدراسة تهدف إلى تقييم برامج التأهيل المبنى على المجتمع في كل من محافظتي غزة وشمال غزة ، بغرض تزويد المعنيين بمعلومات بإمكانها المساهمة في دعم الخدمات المقدمة, وكذلك التعزيز من فاعلية البرامج.
أجريت هذه الدراسة باستخدام أساليب التقييم الذي تربط بين طرق البحث الكيفي والكمي في جمع المعلومات ،وذلك في كل من الجمعية الوطنية لتأهيل المعوقين في محافظة غزة، وجمعية الإغاثة الطبية الفلسطينية في الشمال. وقد شملت عينة الدراسة الكمية 300 من المستفيدين من برامج التأهيل المبني على المجتمع والذين تم اختيارهم بطريقة عشوائية منظمة وكانت مساهماتهم من خلال استبانه تم إعدادها بواسطة الباحثة ، وقد كانت نسبة الاستجابة 69.7%، بالإضافة إلى مراجعة 20 من الملفات الطبية للمستفيدين من كلا المؤسستين، مع الأخذ بالاعتبار مصداقية وصحة طرق البحث.
بينما العينة الكيفية اشتملت على 10 من الشخصيات المهمة،حيث تم انتقائهم بطريقة اختيارية لإجراء مقابلات معهم .
كشفت الدراسة أن السبب الرئيسي للإعاقة مكتسبا ويقدر بنسبة 71.6%، وأنها تشمل أنواع عديدة معظمها من الحوادث شكلت 52.1%، يتلوها الأمراض المعدية بنسبة 16.7% ثم الحروب بنسبة 14.6 %، هذا وقد شكلت الإعاقة الحركية أعلى نسبة 76.1% من بين أنواع الإعاقات.
أظهرت النتائج أن خدمات برامج التأهيل المبنى على المجتمع متنوعة، تتضمن خدمات اجتماعية، صحية، تعليمية وتمكين ذوي الإعاقة في المجتمع. ومن أبرز الخدمات التي تقدمها برامج التأهيل المبني على المجتمع هي الخدمات الإغاثية: حيث شكلت نسبة 49.1% ، يتلوها الأدوات المساعدة للمعوقين 32.6%، ثم العلاج الطبيعي بنسبة 31%، بينما كان هناك قصور في مجال كسب الرزق و

الخدمات المعيشية، متمثلة بقلة التدريب المهني، وكذلك قلة الوظائف لذوي الاحتياجات الخاصة والذي قدر كلاهم ا بنسبة 0.6% فقط وكذلك الحاجة إلى إنتاج دخل شهري لهذه الفئة من الناس، خاصة أن معظم ذوى الإعاقة (81%) يعيشون تحت خط الفقر.

بشأن الزيارات المنزلية ؛ دلت الدراسة على أن 50.3% من الزيارات كانت اقل من مرة شهريا، في حين أن هناك دلالة إحصائية بان الزيارات المنزلية لطاقم العمل أكثر من مرة شهريا أكثر إنجازاً، والذي يعود بدوره حقيقةً على المعوق ليصبح أكثر اعتمادا على نفسه. من جهة أخرى دلت الدراسة أن برامج التأهيل المبنى على المجتمع تمتاز بفاعلية، حيث اسُتنبط ذلك من تلبية البرامج لمعظم احتياجات ذوى الإعاقة، وتحسن فى حالة المعوق نفسيا وجسديا.

وكذلك من مجال تحسن جودة حياة المعوق في ظل الاستفادة من خدمات برامج التأهيل والذي احتوى على مؤشرات عدة هي: شعوره بالأمان،الرضا عن البرامج، والتغيير الايجابي لوضعه الصحى و كذلك مساهمته فى المجتمع، حيث وجدت علاقة ايجابية بين الخدمات المقدمة والتحسن فى جوده الحياة لذوى الاحتياجات الخاصة وصلت إلى دلالة إحصائية قيمتها ( 0.001)، تبين من خلالها انه كلما زادت الخدمات، زادت جودة حياه المعوق.

أثبتت الدراسة أن التعامل الجيد والتفاعل الذي يمتاز به عاملي التأهيل مع ذوي الاحتياجا ت الخاصة شكل أعلى نسبة 37.3% من بين الأشياء التي أعجبت المستفيدين من البرامج ،كذلك أظهرت الدراسة قلة عدد عاملي التأهيل والحاجة إلى المتطوعين مما يؤدى إلى زيادة ضغط العمل والتأثير على سيره وجودته.

بينت الدراسة أن هناك قصور في توثيق المعلومات وكذلك في تقييم الحالات ، وان المجتمع العام يفتقر إلى الوعي حول قضايا الإعاقة المختلفة بجانب حقيقة ضعف مساهمة المجتمع المحلى متمثلا بالحاجة إلى لجان محلية والتي من شأنها دعم و امتداد لنشاطات برامج التأهيل المبنى على المجتمع. إضافة إلى أن قانون المعاق الفلسطيني رقم 4-1999 غير فعال مستدلا من غياب دور ذوي الإعاقة أنفسهم في المطالبة والدفاع عن حقوقهم، وكذلك افتقار مساندة الحكومة في تطبيق هذا القانون.

قدمت الدراسة مجموعة من التوصيات التي من خلالها يمكن تقوية برامج التأهيل المبنى على المجتمع مشتملة على إنشاء إستراتيجية وطنية لخلق الوعي حول قضايا الإعاقة المختلفة، إقامة لجان محلية تقوم بدورها بإنشاء سياسات حول نشاط برامج التأهيل المبنى على المجتمع، دعم دور المعوقين في المجتمع المحلي، تعزيز دور المتطوعين والذي بدوره هو إحدى طرق استمرارية البرامج، وأخيرا زيادة سعة طاقم التأهيل للتخفيف من ضغط العمل والحفاظ على جودته.